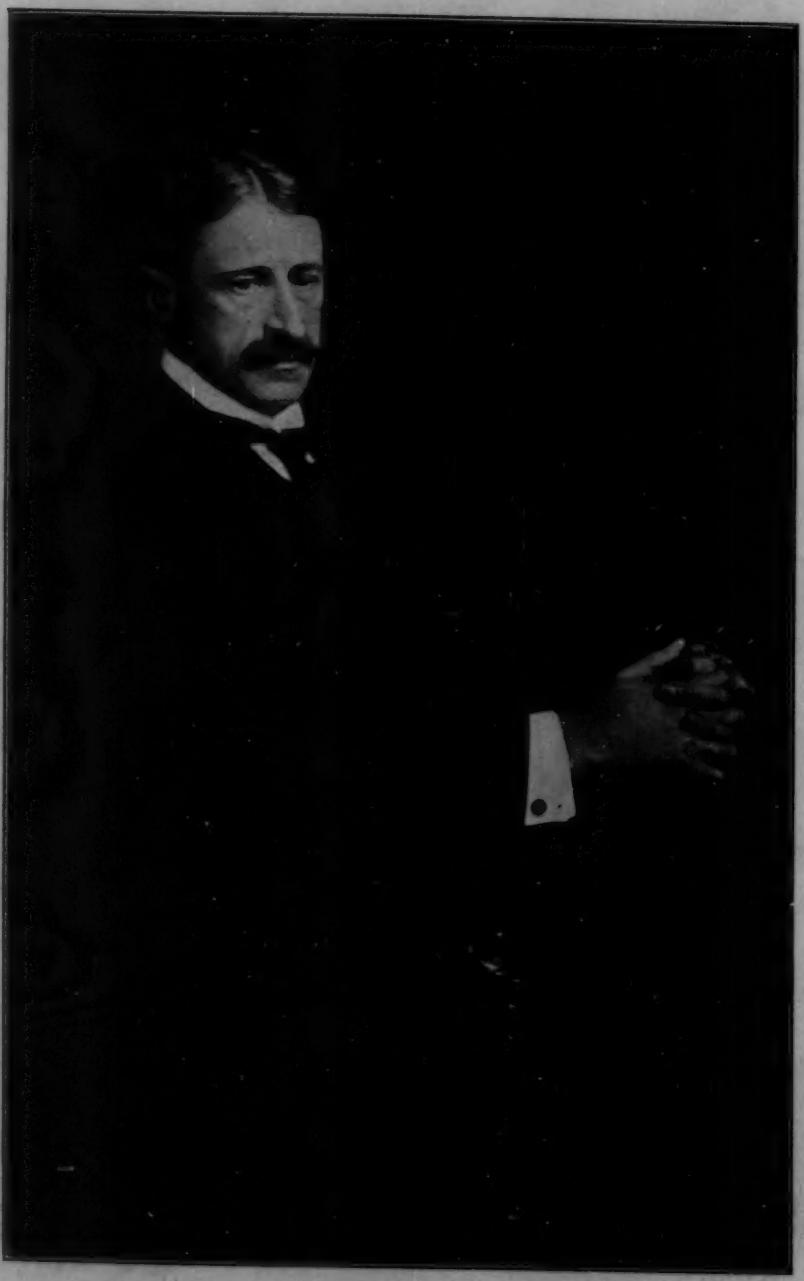

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THE PLACE OF MENTAL HYGIENE IN THE PUBLIC-HEALTH MOVEMENT*

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IT is not because of any particular knowledge in the diagnosis or treatment of disordered mentality or the disturbances of conduct that I am permitted to share in this appeal for an intelligent understanding of the aims and necessities of our committee.

The part allotted to me is that of interpreter of the place of mental health, or lack of it, in the broad plan and service of preventive medicine, in which this country is now engaged through its official and volunteer health agencies. It has been quite inevitable, because of the peculiar genius of American effort, that the obvious, the immediate, the so-called practical needs of the sick should be first met and the theories and principles of prevention and action looking towards health promotion and protection be left until a new public opinion and a keener vision of relative values in medical services could be developed.

The appeal of the crippled child, of the consumptive, of the handicapped sufferer from a failing heart, is so direct and effective that little or no ingenuity or persistence is called for to obtain services to meet their respective needs, albeit nothing constructive or permanent is sometimes accomplished by our effort, beyond the sweet satisfaction of having done all that is humanly possible to relieve and protect, or to assist to better strength, and perhaps even to prolong the lives of the afflicted.

* Read before a meeting held under the auspices of the National Committee and the Massachusetts Society for Mental Hygiene, Symphony Hall, Boston, February 8, 1922.

May I be permitted to suggest that it takes a higher type of intelligence, a greater faith, a truer sense of perspective, to foresee the approach of disease and protect against it, to believe in the possibility of acquiring health and promote it, to see the enemies of health from afar, go out to meet them, outmaneuver them, outflank them, and down them by counter-attack, than to heal or tend existing disease?

This is the spirit of to-day, and nothing less than a determination to force the diseases already known to be preventable to retire, and, by enlarging our knowledge, to include the causes and means of control of those diseases as yet out of reach of preventive medicine, will satisfy the past generations of students of medicine and its allied sciences, whose trustees we are to-day.

It may be said without reservation that, incomplete as our knowledge is of much in medicine and of the true basis of the laws of health, we already have so much at hand which we fail to use that there is no excuse for idleness, and there need be no delay in action.

We have arrived at a point in the organization of our national effort for health where advances in the fields already preëmpted and liberally supported by public opinion and resources must wait for their entire success upon a fair beginning and progress in the most delicate and difficult and yet the most promising undertaking of all—the prevention of nervous disorders and mental defects.

We have seen the understanding of the public roused to successful action against that flail of the human race, tuberculosis, until we now reap rich rewards in a rapidly falling death rate from what has been until recently the cause of our greatest loss of life. In the last year, in the largest aggregation of human beings under one corporate government, in New York City, we saw a rate of loss from pulmonary tuberculosis of 89 per one hundred thousand of population, while but fifty years ago the rate was 408. A reduction of the death rate from tuberculosis of 51 per cent in the past twelve years among the six million people of New York City is an earnest of what can be done in other preventable diseases. Who would have dared to claim or promise any such extravagant

results when the first small beginnings of education in this subject were made, less than twenty-five years ago?

Shall we fear now to see visions and dream dreams of the goal approachable by our successors of the next generation in the field of mental hygiene?

Following hard upon the great anti-tuberculosis inspiration of a generation ago, lighted by Trudeau, Bowditch, Otis, and Biggs, and still a model for volunteer health organizations throughout the world, came the attack upon infant mortality, until last year we lost in New York City but one babe in fourteen in the first year of life, as compared with one in four, which was the experience of our large cities within the past forty years. And still we see possibilities and certain promises of a further reduction of infant deaths to less than half the present most creditable figure, and with this a saving of the mothers of the nation which will entitle us to rank first instead of fourteenth among civilized countries in the safety of the mother at childbirth.

Those devastators of the home, syphilis and gonorrhea, met now by clear thinking and clean speech, by honesty and self-control, begin to halt in their spread, and no one who saw education and high principle coupled with accurate scientific medical practice in the armed forces of our country can doubt that these diseases, too, will be recorded among the defeated ones within the next generation.

Even cancer has shown a tendency to recoil before those enemies of disease, the periodic medical examination, early and accurate diagnosis, and skilled surgical treatment, and yet education and technical resources have hardly begun to reach the mass of people capable of protection.

There enters the field now the intricate machinery of industrial medicine, alert to detect and avert the multitudinous calamities that attend our production of the needs and delights of modern life.

Hardly yet fully understood by physicians, but seized upon even in its incompleteness by teachers and housewives, we are already at grips with the disorders of nutrition, which have broken nations and decided the fates of armies, whether of men or of school children.

Latterly even the end results of other and more obviously

preventable diseases have come under careful medical and social study, and we see heart disease subject to an increasingly successful campaign of education and service, which promises well.

Against the habits of a nation, too, we have seen a gradual reaction follow the force of education until at present we find that most destructive of all habit-forming drugs, alcohol, forced out of commerce in this country, to the obvious and great benefit of all. Since social sanction has never approved of the use of narcotic drugs, we may promise ourselves an early success in controlling them.

It is true that no one of the specific health efforts we are engaged upon is complete in all its details, or has proved what are the simplest and most direct methods, or indeed what is to be the full measure of their success, and yet the plans of the leaders, the lessons of science, are such that we may truthfully say that we have marked out the ground of preventable diseases and allotted the responsibility for cultivation.

As the early enthusiasts have dug into their respective problems, they have come soberly to a common point of view—namely, that each effort in a particular field depends largely upon the state of cultivation and protection in adjacent ones. The workers in the prevention of tuberculosis, the protectors of babes and mothers, the guardians of social hygiene, agree that public health is a whole and cannot successfully be accomplished by a one-sided development dealing chiefly with one organ or function.

Each program of preventive medicine depends upon the thoroughness with which we discover all cases of the particular preventable disease in its earliest recognizable form. The tuberculosis services in New York have accomplished so much that, of the applicants for diagnosis at the public tuberculosis clinics, not less than 66 per cent were found to be nontuberculous in the year 1921. Similarly we are already finding that of those applying for special diagnosis in diseases of the heart at cardiac clinics, more than 25 per cent are not suffering from heart disease.

When can we say that at neurological clinics and psychiatric institutes more than half the people who apply have normal nervous systems and are free from disorders of conduct? Not

until then shall we know that we are beginning to control our problems.

From the point of view of cost, misery, and the numbers of our people involved, mental disease constitutes a larger problem than any of the others. In addition to the beds reserved for the feebleminded and for sanatorium care of the "nervous breakdown", there are as many beds for the insane in this country as there are hospital beds for all other diseases combined. And the significance of this is the greater when we see that the needs of medical, surgical, and tuberculosis patients are fairly met, while less than half of those suffering from mental and nervous disorders who should be cared for under medical direction apart from their homes are at present provided for throughout the country.

Whichever of the paths in the fields of health protection we tread, we cannot escape returning to the crossroad that binds them all together—the protection of the mind, the building of its strength, the guidance of its reactions, the unraveling of its difficulties, the destruction of its enemies.

The worst spreader of tuberculosis is the feebleminded open or active case. Irresponsibility is no more a personal liability alone than is communicable disease. The presence of the feebleminded or of those otherwise irresponsible and incompetent in a family or in a community constitutes the danger point in all the communicable and occupational diseases and drug addictions. How much of the burden of disease prevention can you put on a child of ten? How many adults are there in the United States with a ten-year-old mentality?

The control of all of the communicable diseases depends on early recognition of the conditions, their treatment, and, if necessary, the segregation of the patient. If we were free from the incubus of the feebleminded, our control of venereal diseases would be infinitely simplified, for whether among men or women, the spreaders of these diseases are chiefly those who are incapable of self-restraint or self-control, those who are inattentive to their physical health and fail to understand and follow the teachings upon which we depend to carry health and self-protection to the intelligent.

In the saving of maternal and infant lives, again, we come upon the irresponsible mothers of the illegitimate, where the

infant death rate is ten times that among children born in wedlock and reared with understanding of the simple rules of cleanliness, the necessity of constant protection of babyhood.

The accident list, the poison list of industrial workers, the turnover in shops, all represent problems of mental and social inadaptability of the wage earner, greater in extent, the lower the wages and the more precarious the occupation. Still we must attempt to deal with the physical conditions of workers alone for lack of guidance, education, and analysis of industrial human wastage by the psychiatrist. We see at least 75 per cent of poverty due to disease and more than half of this determined by mental incapacity or aggravated by disorders of conduct.

If the preventive service of the mental-hygiene movement had nothing else to its credit, we owe it the great dividends which have come from its teachings of the need and possibilities of occupational therapy. During convalescence and even in the midst of sickness, patients now work their way to health. The psychological asset of *busy-ness* in a hospital ward is now accepted.

The principles of the campaign for mental health are similar to those of other health problems. The technic of approach follows the methods used in diphtheria, in malaria, in infant mortality:

1. What is the extent and direction of the attack on the human mind?
2. Where is the enemy hitting?
3. What are his weapons?
4. Are the causes of his success primary attack on the mind or secondary effect of his by-products on intellect and emotions? Are they hereditary, infections, habits, customs, fears, superstitions, or religions?

We must have:

First, facilities for the examination of mental as well as bodily or physical fitness and performance. These are clinics, observation stations or wards, an alert and expectant body of trained physicians, and psychiatric social workers or nurses.

Second, records of the present distribution and incidence of mental disease and nervous disorders. Such records obviously must be continuous, to permit of comparison between com-

munities, and from year to year, and to give us hope of progress and a warning if our results are not improving.

Third, the survey or community diagnosis, which is needed for state, town, or county as it is for the individual patient. There is no essential difference in principle and objective between this and the surveys with which the public is familiar in tuberculosis, hookworm disease, blindness, or among cripples.

With survey facts—or, in other words, the diagnosis of a community—in hand, we can apply our education pointedly to the public. A public well informed on dangers and their causes spends freely for self-protection. For five dollars spent on diagnosis, the community will spend one hundred to a thousand on preventive treatment.

With research we arrive at new bases for social conduct and release ourselves for a new conception of the function of school, prison, court, and shop. With the new idea conceived by the student and proved by his research, we embark with confidence on demonstrations in mass to prove the result in practice.

To direct our efforts, we need a specialist in preventive as in curative medicine. This specialist shall be our consultant in mental hygiene, for school, prison, and shop, to whom educators and employers can come for advice. Our committees for mental hygiene serve the purpose of community consultants in the problems of mental health. These committees, both national and local, are the research students of the community, and execute studies on man in the mass, as the human discloses the manner of his mental defects only in contact and in conflict, in competition with his fellows.

The committee is also the center for the accumulation and distribution of exact information, to assemble, prove, and encourage results and warn new community efforts of failures due to old methods and unsound technic.

The specialist service for mental health will do in peace what the special consultant did in the American Expeditionary Forces—that is, save the mentally fit from the too common civilian practice of abusing, imprisoning, penalizing, and brutalizing the mentally feeble, the misfit, the temporarily disturbed. Specialist service means the same gentleness, judg-

ment, certainty, and success in saving minds as it does when applied to the saving of limbs, eyes, or lungs.

What we as a committee are searching for is some touchstone of humor, some gilded gift of oratory, some inspiration of the teacher which will give *us* a change of mind.

Why was it a disgrace twenty-five years ago to have consumption in the family?

Why did we hide cancer?

Why in our self-righteousness do we hide the syphilitic? Because we have had too little courage to seek and know the truth and prevent through knowledge rather than hide in ignorance.

So now we can see a time when the strange child, the strained mother, the confused and hounded workman will appeal to hospitals for relief from the twisted personality, the beaten brain, the incapable self-control as they now run to them for diabetes, appendicitis, or typhoid fever.

Why a broken mind or a half-developed character should be considered a disgrace, when broken cardiac compensation and lame joints are matters almost of family pride, is hard to see. Our education in these matters can't rise higher than its source. The medical student, until recently, has seen all varieties of flat feet and rarely had the army of deformed minds and characters passed before him. The psychiatric social workers of to-day are better educated in the causes and manifestations of the mentally abnormal than the rank and file of the medical profession.

This new conception of the social service of medicine through the practice of prevention in mental hygiene is proving a blessing to the physician of the body. It is reincarnating him as a physician of the personality as well.

We can't go forward on any public-health campaign without:

Public understanding.
Medical education and leadership.
Facilities for diagnosis and care.
Study, research, and information.

All health campaigns have gone through these phases. The principles are similar in all; the results in mental hygiene

promise more than others because of the quality of them. The essential spirit of health and happiness is mental and has a future as far beyond that of physical-disease control as the mind of man is the greater objective for which we build the healthy body.

As a student and practitioner of preventive medicine, I appeal to you, the public, to put into our hands as trustees the wherewithal to teach all that can be learned and applied for the discovery, protection, and repair of disordered minds. Until you feel this burden and this hope as you were convinced of the truth by the disciples of the anti-tuberculosis campaign of twenty years ago, your truly democratic generosity in the other fields of public health will not bring in its best or final returns.

You are asked now to reduce the salient of mental disease which dominates, as did the St. Mihiel salient, all other incidents in the grand attack.

Whatever the field of effort, investments in preventive medicine have brought in bonanza dividends far surpassing the prophecies of professors or health officers.

In our relations to our fellows, we owe them truth and escape from ignorance, faith in the lessons of science, the experience of physicians; or, as it has been better put by one who spoke of "Health as the first Wealth":

"A few great points steadily reappear, alike in the poverty of the obscurest farm and in the miscellany of metropolitan life, . . . These few are alone to be regarded; the escape from all false ties, courage to be what we are, and love of what is simple and beautiful, independence and cheerful relations, these are the essentials—these and the wish to serve—to add somewhat to the well-being of men."

The opportunity is yours.

The knowledge is ready.

The way is clear.

The facts call loudly for action.

THE PATIENT AND HIS ATTITUDE TOWARD HIS NEUROSIS

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ALL individuals suffering from the so-called functional disorders of the nervous system naturally fall into one of two groups, according to whether the reaction toward the neurosis be an active or a passive one. The individual that belongs to the active group I conceive as seeking refuge in his neurosis. He is usually the inherently unstable individual, and it is because of this instability that the neurosis develops. The motive is usually obvious to the physician, although not to the patient, and also active—that is, it is present at the same time that the symptoms, whether objective or subjective, are being manifested. The symptoms are more frequently of a crude character, and the patient clings to them with great persistence. They not infrequently recur when the patient finds them to his advantage. The physician's emphatic index (attitude) toward these individuals is usually low, as the patient admits improvement with great reluctance. Suggestion is the treatment most frequently utilized in this particular group, and perhaps the two most common examples presented in the war neuroses were the anticipatory neurosis, found so frequently in the training camps, on the way overseas, and immediately upon arrival at the scene of conflict, and the compensation neurosis, which we are meeting frequently at the present time in dealing with the aftermath of the war.

To the second group, which I term as passive, belong those individuals who do not seek, but are overtaken by, their neurosis. Not infrequently these individuals appear to be normally stable. The motive or purpose of the neurotic symptoms is usually obscure and may be considered as inactive—that is, the stimulus itself is not in operation in conjunction with the symptoms, but only the emotion that was

attached to the primary experience. These individuals develop their neuroses in spite of their stability. Their reactions are more elaborate and are well exemplified in the amnesias and psychasthenias. They reach out blindly for help and are eager to note improvement; consequently the attitude of the physician (empathic index) is high, and there is an eagerness on his part to aid these individuals in making a proper adjustment toward life.

The following case is one that I conceive as belonging to the passive group—that is, it is the case of an inherently stable individual who is overtaken by his neurosis rather than seeking it.

Case 1: The patient's family and personal history are negative. He entered Base Hospital 117 about the fifteenth of September, 1918, and at that time had a complete amnesia for all events from the morning of April 11, 1918, up to and including October 25. The last event that he remembered prior to the onset of his amnesia was his landing in Liverpool and the first part of his march from the docks to the train. The intervening six months and fourteen days were a complete blank, and his first recollection after this amnesic period was of being arrested by one of the military police, whom he told that he was looking for his lieutenant, but to whom he was unable to give the name of his division or company or their geographical location. The patient was interviewed daily for eight days, an effort being made to restore the lost memory by means of association. Because all the events prior to his landing in England—that is, his early life, his occupational and school history, and military life—were intact, although he could not by associative methods go beyond his experiences on arriving at Liverpool, he was subjected to hypnosis and his entire memory restored in about two hours.

The points of interest that occurred during the amnesic period are as follows:

The patient landed in Liverpool April 11, 1918, and marched from the dock to the boat for Le Havre, arriving there April 15. He went into detail in telling of various moves from that date up to July 18, when his company was in position along the Marne River just to the right of Chateau-Thierry. He was in reserve at Chateau-Thierry, and was relieved

July 31 and sent to St. Mihiel, where he was held in a reserve position for the big drive. From that salient, his company was moved by auto-trucks to Souilly. Here he was transferred to the second battalion of the Fourth Infantry. On the second night his battalion moved up and relieved the first battalion. The next morning, when he got up, he found that he had been separated from his company. He states:

"I looked around all day, but was unable to locate the outfit. At night I returned to Montfaucon and slept. The following morning I returned to the train to go up with the 'chow detail', but it had already gone. I looked around until about one in the afternoon for my company, but without results. I then returned to the train, and Lieutenant Gamon, the officer in charge, told me where he thought my company was located. A detail was then going up to them with chocolate and other things, so I started out with them. We could not go through Montfaucon, as 'Fritz' was shelling it, so we took another road. Some shells began dropping on the road, so we lay down and waited for him to ease up. After about fifteen minutes, he stopped. There was only one of the men besides myself in sight, and we disagreed on which way the others went, so we separated to look for them, but I soon decided not to bother looking for them, but to go on with the company.

"The Germans had stopped shelling the town, so I went back and through. I left the road to cross the field to reach the woods where the company was located. As I crossed the field, I saw a man coming toward me. I did not recognize him as a friend, only as one of the company. *When he was twenty feet from me,* I heard a shell coming *and lay down. The shell struck him in the neck* and knocked his head off and buried itself in the ground about two *feet from me.* As I lay there on the ground waiting for the shell to explode, I could do nothing but look at his head. I was never so frightened in my life. I do not know whether *I was more frightened of the head* or *whether it was expecting the shell to explode.* Anyway, it did not explode. I tried to get up, but could not, for I was so weak I could not move. I remained there five or ten minutes, I suppose, but it seemed like several hours. After a

while I got up to go to the camp and a shell came over. I did not hear it coming. There was just a puff of smoke, then darkness. When I came to, I was about eight feet away from where I was first lying. I remember nothing else until the military police arrested me when I inquired for Lieutenant Gamon. I do not remember whether I went on to look for the company or whether I turned back. I believe it was the next day that I was picked up by the military police."

It was of interest to note that the patient, under hypnosis, showed little or no emotional reaction until he came to the event that was the exciting cause of his amnesia—that is, seeing the head of his comrade blown from his shoulders and lying in close proximity to a shell which he expected would explode. At this point the patient showed what was presumably the same emotional reaction that he had had during the actual event, exhibiting all the physical and mental manifestations of terror.

With reference to the amnesias, it is worth while pointing out that in these war situations, although the amnesia protected the individual from the memory of an intolerable situation, it did not incapacitate him from returning to the front. In fact, the amnesia in itself prevented an emotional reaction that would have incapacitated the patient for active service. This was clearly shown by the fact that the clearing up of the amnesia was frequently followed by an anxiety neurosis. We invariably found that it was a rather superior type of individual that developed amnesias during the war. We found that post-concussional confusions followed by amnesic periods, without any particular emotional disturbance, often cleared up suddenly and without any interference from outside, but the amnesias produced by psychic trauma would apparently persist indefinitely unless an effort was made to aid the individual to regain the lost memories. In a great majority of the cases, it was only the least automatic and the least organized forms of memory that were attacked, but occasionally we found that the habits and acquired skill of the individuals were forgotten in cases precipitated by psychic trauma.[1]

[1] I recall seeing two cases with Professor William McDougall, then at the Third Southern General Hospital, Oxford, where the reversions to infantile conditions were almost complete, even in talking, walking, eating, etc.

It is also of note that the toxic and concussional amnesias were never so absolute as the emotional group and they rarely cleared up as completely.

Case 2 (Active Type): This patient is an extremely well-developed and well-nourished young man, weighing two hundred pounds, height six feet, three inches. His family history is negative except for the father, who was alcoholic, and who is said to have had mental symptoms at the time of his death. The patient himself finished grammar school at fourteen, does not use either alcohol or drugs, makes friends easily, and has been able to adjust himself socially. Immediately following his typhoid injection at Camp Devens in October, 1917, the patient stated that he had had a queer fit in the night. These fits have continued every night excepting one up to the present time. They vary in number from three to thirty-five and are always of the same type: the patient suddenly turns over in bed and buries his head and face in the pillow until he loses his breath; then he lifts his head to get air and wakes up partly conscious. During part of this episode, he is unconscious; during the other part, semiconscious, but unable to speak. He remembers most events that occur.

He was awarded Federal Board training in January, 1920, and started in to learn the shoemaker's trade. He was allowed $80.00 a month by the government while in training. He remained at it only one week, when he gave it up and entered the hospital. After his discharge, the Red Cross found a position for him at light out-door work for four hours in the morning. This position he gave up after one day, saying that his sister had to get up too early in the morning to get his breakfast. The patient has been diagnosed as a psychoneurotic epileptic and treated for glandular insufficiency without any success whatsoever.

The physical examination was negative, excepting that the X-ray examination revealed what appeared to be some infringement of the pituitary by the clinoid processes.

The patient has been examined by a great many physicians. He takes a rather keen interest in the fact that his condition has not been diagnosed. He has considerable anxiety about his compensation, is very anxious to get a total permanent disability from the government, and lays more stress on this aspect of his case than he does on being cured. When asked

to come to the hospital for observation, he states that he will come in, but he wants it understood definitely that it is the last time that he is to enter a hospital. His general attitude is friendly and semi-coöperative. One feels that he is rather passive in his attitude toward getting better. On the other hand, he makes the necessary formal concessions for treatment.

We are here dealing with a condition that is psychogenic in origin and that fulfills to a very large extent the requirements of the neuroses of the active group. There is no evidence of any organic disturbance to account for the convulsive phenomena, neither are there any clinical manifestations to make us feel that it belongs to the group of idiopathic epilepsies. There is no evidence of any mental deterioration whatsoever, consciousness is never completely lost, and there is no reason to believe that other than the higher levels of the nervous system are affected. The man has been examined and reëxamined by various specialists and has received almost every drug in the pharmacopeia, although he admits that they have been of absolutely no benefit to him. One can conceive of the patient's primary neurosis as having been of the anticipatory type and the preservation and exaggeration of the symptoms of a compensatory nature.

It is rather frequently found that men who developed an anticipatory neurosis in the camps and on their way overseas are at the present time returning to the hospitals and clinics with a compensation neurosis.

There should ever be borne in mind the possibility—even the probability—that a very considerable proportion of the so-called war neuroses or mental conditions (not definitely psychotic) belong to what are commonly called the anxiety states rather than to the actual neuroses. These men are quite conscious of the pathogenic factors that are producing both their objective and their subjective symptoms. This fact has been strikingly demonstrated, both in this country and in England, by the tremendous increase in the number of men applying for treatment and compensation during the recent months of economic depression, and the complete cessation of symptoms following the alleviation of financial stress either by the securing of employment or the obtaining of compensation. Domestic difficulties, failure in vocational

training, disappointment regarding compensation, are commonly met with as exciting factors, producing a state of anxiety that is not out of relation to the stimuli producing it, and invariably the patient is quite cognizant of what his real difficulty is. These situations, of course, are very largely social and economic and must be treated as such.

Since the signing of the Armistice, it has been necessary to make some radical changes in our treatment of the functional nervous disorders that have been produced by mobilization, war activities, demobilization, and all the problems arising in this most critical period, which may be termed the transition of the soldier to civilian. At first thought, one would naturally presume that the results of treatment in these disorders would be decidedly satisfactory, more rapid, complete, and lasting. In fact, it was reported, shortly after the cessation of hostilities, that that event in itself would be sufficient to cure all the neurotic cases. But regrettable as it may be, the fact remains that we are still concerned with a problem that is not only of no small magnitude at present, but that is far from having reached its maximum, either in the number of cases to be treated or in the resistance that these cases are going to offer to treatment.

During the hostilities we had to face, in many instances, what appeared to be an insurmountable difficulty. We not only had to cure the man of his functional disability (deafness, mutism, paralysis, etc.) or to help him to assimilate and accept the reality of some terrifying experience, but we were also concerned with the problem of getting these men ready to return to the very environment that produced their original difficulties. In civil life it is considered wise and judicious, whenever feasible, to remove the patient from the environmental factors that produce his symptoms, but during the hostilities, the value of our work was measured by the number of men we were able to return to the field of battle. This difficulty is, to a large extent, removed in dealing with cases at the present time, yet, on the other hand, during hostilities we were dealing with the soldier and not with the prospective pensioner. We could appeal to his patriotism, to the traditions of his company, to his desire to get back to his comrades, and in many other ways stimulate his gregarious instinct to activity. The average soldier disliked

hospitals, with their monotonous routine. Treatment was firm and persistent. So on the whole there were many reasons that, when taken together, furnished an incentive that was a very important factor in the man's recovery. At present we are dealing with individuals over whom we have no legal or military control. A man can refuse or accept treatment as he wishes. No longer can we say to the soldier incapacitated by an hysterical paralysis: "You have been sent here for treatment. I have examined you and find that your condition is perfectly curable. I am going to cure you. It may take ten minutes or several hours. It depends upon how much you want to get well and how much you are willing to help me. When you leave the treatment room, you are going to be absolutely all right." This was the statement that we could make to our patients during the hostilities and feel sure that we would be able to keep our promise and get the desired results. It was a matter of being sure of your diagnosis and confident of your ability to remove the functional symptoms. The control and authority over the patient took the place, in a large measure, of the coöperation for which we have to beg at the present time. Very recently I made four definite engagements with an ex-soldier for an examination before he came to the office. I found he was drawing $90.00 a month for hysterical paralysis of the left arm and making weekly visits from a Vermont town to Boston for treatment. If I am not mistaken, he will be more difficult to cure than a similar case would have been three years ago behind the lines.

The problem with which we are confronted to-day, with reference to the neuropsychiatric cases, is very largely one of adjusting this active type of the neurotic group to their environment whenever possible. One realizes that in many instances this adjustment was far from perfect, even in prewar days, and one should not hope for too much under present conditions. The great majority of these individuals returned to their homes after the war and for a longer or shorter period adjusted themselves to the old environment more or less efficiently, some poorly for only a few months, others very satisfactorily for a period of two or more years. Eventually we find that the present breakdown has been precipitated by some very definite environmental pathogenic factor. It may be an accident or an illness to the patient, possibly some sick-

ness in the family or financial loss, more likely unemployment or domestic difficulties. There are innumerable incidents of varying severity that may act as the exciting cause of a so-called nervous breakdown. It is during this period of social and economic maladjustment that the individual first makes contact with one of the numerous agencies interested in the ex-service man. He finally reaches the Veterans' Bureau, is put through the usual routine examination, and an effort is made to connect his disability with his war service. It may be frankly stated here that this is frequently no easy task. However, the fact is recognized that the man needs help, but more frequently than not the assistance that he needs is financial rather than medical, and the hospital is used as a means toward this end. The man's anxiety regarding his own condition, which has been built up by a process of rationalization, is substantiated by this step, yet the economic stress has been relieved; so, on the whole, it is accepted by the patient as a fairly satisfactory solution of his difficulties—that is, he reasons that if he were not ill, he would not have been sent to the hospital, and the fact that he is hospitalized entitles him to compensation, which dispels his anxiety over economic worries. In a recent report to the Surgeon General of the United States Public Health Service, by Dr. H. Douglas Singer and the writer,[1] the following statement was made:

"In essence, the neurosis is a 'way out' of some intolerable conflict or difficulty. The feelings of stress, apprehension, and worry that belong to the conflict are interpreted by the patient as evidences of disease or injury, the origin of which is referred back to some accident or illness—gassing, influenza, overwork, etc.—of the more or less recent past. The suffering is genuine and none the less real because the symptoms are ascribed to disease or injury."

And later:

"To place such a patient in a hospital is to confirm his belief in the existence of serious disease or damage. Furthermore, it very effectually brings a cessation of the responsibilities and needs for adjustment that brought about the

[1] See *The Care of Neuropsychiatric Disabilities Among Ex-service Men.* By Douglas A. Thom and H. Douglas Singer. MENTAL HYGIENE, Vol. 6, pp. 23-38, January, 1922.

disorder. It is often extremely difficult to discharge such patients; it is a much simpler problem to keep them out of a hospital. No man can be taught to carry a heavy burden by being relieved of the necessity for carrying anything at all. It is true that in some instances the burden may be more than the shoulders can bear. The shoulders must then be trained to bring them to their full strength. If it be found that the load is still too great, steps may be taken to diminish it, but it must not be removed entirely unless we desire to retire the individual from active participation in life."

After a most careful consideration of a plan that would seem feasible to rehabilitate this ever-increasing army of psychoneurotic individuals, that of well-organized out-patient clinics offered more advantages and fewer disadvantages than any other. It will be necessary, however, that compensation be utilized as a treatment measure in order that the patient and his family be provided for while he is under treatment. The organization of such a clinic will require an adequate staff of psychiatrists, psychiatric social workers, and a psychologist. In the larger cities, it will be found that the psychiatrists can be drawn from the men in practice who are willing to put in from one to three half days per week. To a very large extent social workers will have to be trained,[1] and arrangements for the same will have to be undertaken by the organization that assumes the responsibility of doing this rehabilitation work, whether it be the government itself, the Red Cross, or some other organization. The psychologist should be able to do much in aiding the prospective trainee in his task of selecting a vocation.

If the ex-soldier is rehabilitated in the environment in which he is to live, without the introduction of any motives that would tend to put a premium on the continuation of his symptoms, if he is treated by physicians who are trained and experienced in this particular branch of medicine, assisted in making his social adjustment by trained psychiatric social workers, and tested and measured to determine, in so far as possible, his capabilities and chances for success in industrial pursuits, one can then hope for a fair measure of success in

[1] Special training for psychiatric social work is now provided at the Smith College Training School for Social Work and the New York School of Social Work.

the tremendous task at hand. The problem of developing both a psychiatric personnel and a psychiatric social service must be met at once. The folly of appropriating millions for hospitals and organizing clinics without developing men to staff them is obvious, and steps are now being taken by the United States Public Health Service to have these needs fulfilled.

Closer coöperation between the departments that have to do with training, treatment, and compensation was brought to the attention of the Surgeon General in the same report to which I have previously referred,[1] from which I quote the following:

"There is no aspect of the problem that has to do with the rehabilitation of the ex-service man, except that of medical personnel, that is of such vital importance as the close coöperation between the departments that have to do with treatment, training, and compensation. Perhaps, to one who is not in actual contact with neuropsychiatric cases in a medical way, the logical sequence of events would be to restore the patient to the highest degree of efficiency by therapeutic measures before beginning to train him for some trade or profession in order to establish his economic independence. Under this order of procedure each department would work quite independently of the other, and the man would be shifted from one to the other whenever a cross section of the individual indicated the need for a change. However, as all of us who are dealing directly with the ex-service man know, this cross-section method has proved a definite failure. What is needed is a longitudinal section of the patient's life in order that we may consider his past experiences, his present needs, and his future possibilities. For example, if we are dealing with a mentally deficient individual whose war experiences have rendered him incapable of adjusting himself to his present environment and conditions, although his history prior to the war shows that he got along fairly well in the community, we cannot neglect his present needs, which may mean the actual necessities of life. These, of course, can be met only by compensation; and while future possibilities for this patient may or may not lie in training, certainly in such a case

[1] See note page 242.

training can be of advantage only if selected after a careful study of the mental equipment and temperamental fitness of the prospective trainee.

"The question of who is best fitted, by reason of experience, training, and opportunity, to decide upon the presence or absence of the particular qualities that account for success or failure in an individual is quite debatable, but, other things being equal—that is, intellect and opportunity for observation—it seems that the psychiatrist who has made a study of the particular case is best qualified to advise regarding the type of work for which the individual is best fitted by virtue of his physical and mental equipment, as well as by temperament and disposition.

"We very frequently find the man with a mental age of twelve to fourteen years struggling along in some trade or profession that is obviously not within his grasp. The more ambitious and persevering the man, the greater the conflict between his ambition and his achievements, and sooner or later we find him seeking refuge in a neurosis. The same is true when an individual fitted for manual work begins to take up accounting; when the lad who craves outdoor life finds himself shut up in a factory; when the man who is quick and impulsive is forced to do work that requires caution and deliberation; or when the individual who works well under supervision suddenly is thrown into a position that demands responsibility. All of these individual questions must be considered when dealing with problems of vocational guidance.

"We do not intend to convey the idea that the neuropsychiatrist should take the place of an expert trained in the problems of vocational guidance, but that he should advise with this expert or furnish him with all the data at hand pertaining to the prospective trainee's mental equipment and temperamental fitness for general types of work. It seems to us that in this way many of the glaring mistakes that have occurred in the past will be obviated. It may be well to repeat what has already been said elsewhere—that a large percentage of the relapses among the neuropsychiatric cases in training are directly due to their being shunted off into some trade or profession for which they are unsuited."

The necessity for a broad and comprehensive plan that will include every available means at the disposal of the government is quite apparent. Physicians with tact and skill, social workers armed with proper training and experience, psychologists with judgment and foresight, and a smooth and efficient working administrative organization are essential to the rehabilitation of the ex-soldier incapacitated by mental illness.

In an article published nearly three years ago on this very problem of rehabilitation,[1] I endeavored to point out some of the difficulties that would be encountered in our effort to liquidate our debt to the disabled ex-soldier. I stated that there is an inertia both mental and physical, often associated with depression. Some of these men are imbittered. They feel that they have a grievance against the country for which they have sacrificed so much. They seem to be viewing the world through colored glasses; the period that begins with the soldier's recovery and continues through his convalescence, his discharge, his return home, his efforts at seeking employment—in short, that transition from the soldier back to the civilian—is perhaps the most trying in his career. It is fraught with many disappointments. The glamour and glory of being a warrior are no longer present, the comradeship of his fellow-soldiers is gone, all the excitement has passed away; it seems for a moment that life holds nothing worth while. Its emptiness becomes oppressive. The soldier feels himself forgotten. The perils of this period of transition cannot be overestimated. Any plan that involves the independence and happiness, not only of these soldiers, but also of their families, cannot be taken too seriously. The efficiency with which the problem of restoration is conducted through these next two or three years will be reflected in the generations to come. Later, I stated that our chief danger is going to be in taking the path of least resistance, refusing to settle the problem to-day because it is difficult, forgetting that in a few months it will be hopeless. If the public allows the disabled soldiers to drift back to civil life, satisfied with some temporary misfit of a job that can only serve the purpose of a livelihood for the person, we shall be confronted in a short

[1] *Transition from Soldier to Civilian.* By Douglas A. Thom. *The Medical Quarterly, The Canadian Journal of Rehabilitation,* Vol. 1, pp. 342-49, October, 1919.

time with thousands of pauperized soldiers. The result is inevitable. It seems worth while to sound this warning again.

Let us not forget that most of these lads gave the best of what they had. There is a limit to the amount of physical stress and mental strain that every individual is capable of withstanding, just as there is a limit to the intellectual heights that each of us may reach. The neurosis is the individual's effort to seek a happy solution of his problem, crude, cumbersome, and misdirected, but none the less an effort. We must keep in mind that although the motive for the neurosis may be perfectly obvious to the physician, it is not so to the patient; that is why it is a neurosis. Frequently we use methods that are ill adapted to the particular case; as some one has said: "The pick and shovel are used when a rake could do the work." Yet this is not the greatest danger. More frequently, we find that the terms "faker", "malingerer", and "gold-bricker" are used by those who, failing in their therapeutic efforts, seek consolation in this method of rationalization. We should bear in mind, as I have stated elsewhere, that there is no nation in such a favorable position as we are to do justice to the problem under discussion. Our problem, large as it is, does not approach in magnitude that of other nations. We are dealing with individuals who to a large extent belong to the big class of occupational workers. They are just in the bloom of life. Forty years would probably not measure the path that these men have still to follow, and we are to decide to a large extent what these years shall hold forth for the ex-soldier.

PSYCHIATRY, PSYCHOLOGY, PSYCHOLOGISTS, PSYCHIATRISTS*

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THE principal aim of the science of mental life can hardly be other than a right understanding of mental activities—in order that human beings may experience the best possible mental growth that brings better accomplishment and more happiness. What does the science amount to, or of what concern is our attitude towards it, unless results are produced, distant or immediate, for our human kind?

My specific text is a certain alignment that has taken place—psychiatrists over against psychologists, or at least psychiatry over against psychology. But there is more to the matter than these positions taken; considerations are at once implicated that have to do with the very upbuilding of the science itself.

We must see perspectives; to begin with, how nascent we are in this task of trying to understand the inner life of the human animal. Psychopathology has only lately first won some apparently basic facts, applied psychology is now in the throes of coming into being; the study of mental mechanisms as bearing upon practical issues is altogether recent, the age-level arrangements of the few mental tests that we use began only a dozen years ago or so. On the other hand, there are many pathological conditions of mind poorly defined and resting upon unknown bases, and there are yet to be recognized and studied for norms plenty of "intelligences" or capacities that we need to know about in order to grasp the significances of many reactions in life.

Compare the growth of psychology with that of the other sciences whose subject material surely cannot be as complicated, the mind being the most complex organism in our universe. Here we see physics, for instance, just for practical

* Read at the meeting of the American Psychological Association, Princeton, December, 1921.

ends examining and dealing with materials through conceptions and formulæ and methods of approach that are immeasurably finer spun and better thought out than any that exist as yet in our field. Shall we not venture to expect such developments with us or with those who follow us?

Our achievement so far in understanding the life of the mind is, of course, built upon contributions from mental pathology as much as from normal psychology. Great enlightenment has come from those in the medical profession who have been students of deviations from the normal, much in the same way that investigations of bodily disease have been essential to the development of our knowledge of physiology. But in the field of mental pathology we find one portion—namely, that of mental defect—which for generations has been under control of the medical profession, lately made particularly fruitful by the psychologist. Indeed the recent work of psychology with defectives has already proved most valuable for the growth of better understandings of many facts concerning mental life. Mental defect is evidently not amenable to medical therapy, but concerning social therapy, practical adjustment, it is rich ground for the educational psychologist.

The situation to-day presents the psychologist and the psychiatrist both attempting to gain deeper knowledge of the constitution of mental life—and, fortunately, both without confining themselves to special theories. Difficulties are arising because of attempts to interpret mental life or behavior in particular cases without taking into account, not only the viewpoint of the other side, but also part of the factual material obtainable as it bears on the whole problem in hand. Are illustrations necessary? The naïve accounts of mentality in terms only of "intelligence quotients" on the part of so-called clinical psychologists (a term which I considerably dislike) can be paralleled by even recent reports by psychiatrists of cases and whole series of cases where mental capacities (intelligence?) are quite obviously most important factors, and yet no notice whatever is taken of the possibilities of objective determination of such prime elements of the mental life.

The psychiatrist comes to what sometimes is almost purely a psychological job with a very curious lack of training, not

only in an up-to-date psychological technique, but, what is worse, often without a knowledge or appreciation of just where psychology stands to-day. In the medical curriculum one spends much time on organic neurology, but it must be confessed that knowledge of even the finer anatomy of the brain or of its pathology leads but a very short distance toward knowledge of the mind. Why, even concerning mental diseases, in psychiatry itself, the cry is that medical schools are offering very little instruction. In fact, what is there in the whole of an ordinary medical education that in any way justifies the physician in qualifying as a psychologist? If medical men have attained position even in the world of medico-psychology, it is because they have trained themselves otherwise than in formal medical education or in the medical schools.

In dealing with adults, whose educational and life adjustments are for the most part made, the descriptive data of mental disease has usually been considered enough of psychology for the psychiatrist, but with the pushing back of genetic investigations to the really formative periods of life and with the advent of the psychiatrist among children, working very rightfully for mental hygiene, a formidable body of very different sorts of psychological fact is, or should be, met. Whatever one's school of modern psychiatry, it seems to be acknowledged that it is the affairs of adjustment of the individual's mental life that are fundamental for study. Adjustment, certainly at an early age, involves volition, emotion, habit, associations, the various elements of intelligence, memory, judgment, apperceptions, etc., and even imagery type and special learning capacities. These afford important data for evaluation in addition even to the wonderfully valuable matters pertaining to the mental mechanisms which have been so stressed recently in psychogenetics. There are vastly important matters concerned with function, yes, but there are underlying these the facts of structure, of potential.

Is it necessary to say that many such data belonging to individual or differential psychology and educational psychology are quite generally overlooked in psychiatric practice, or that these are important for an understanding adjustment? (Shall one cite, for instance, the immensely interesting problem of the relation of school adjustment, so important for mental

hygiene, to special mental aptitudes?) Or need one call attention to the burden of work for the psychiatrist if proper study is to be undertaken of the data of differential and educational psychology?

We have the very obvious weakness of the position of the psychologist who attempts to pass judgment upon problem individuals in that he has had no good training whatever in knowing the effect of abnormal processes, physical and frankly mental, upon the mental constitution and function. Even invading the school system where he would seem peculiarly to belong for the purpose of diagnosis of individual problems, he is in considerable danger because of possibilities of overlooking abnormal personality trends and even mild psychoses, to say nothing of other dynamic features of mental life which are not brought out by tests and other observed reactions. And when it comes to the handing out of opinion about young individuals by teachers who have had a few weeks' of training in testing, who are not even "clinical psychologists" (we know whereof we speak), the situation is bad indeed.

Attempt to cover the two fields is nearly always unfortunate. Some psychiatrists are using some few psychometric tests without even a few weeks of training, we might say without anything like the education in technique that is demanded for bio-chemical tests. And as for covering an adequate range of tests and the skilled interpretation of the results of tests, altogether harder and most necessary, the importance of this has not struck in at all. I am not aware that there is any such extensive similar undertaking on the part of practicing psychologists to cover the ground of psychiatry. Protests have well arisen against commitment, through courts and otherwise, by psychologists because they are not qualified to give a medical and psychiatric examination, but if one may be allowed to speak from long and varied experience, protests can much more justly be lodged against physicians and even psychiatrists who offer opinions and sign commitments concerning purely psychological matters equally without proper psychological examination.

As time goes on, I find myself more and more inclined to question the extraordinary values placed on classifying the individual nowadays by the results of a limited number of

tests—an exceedingly limited number, considering the immense complexity of mental powers and processes. It seems as if this sort of study of mentality was aiming at something nearly as simple as a statement of body weight or of a plus or minus reaction of the blood. Does not a numerical report of intelligence seem absurd if taken alone, without analysis and statement of special powers and incapacities? I wonder how many of us would feel that we might be fairly known with regard to our mental capacities by our "rating" on any one of the sets of tests. We find accepting this ready method not only practically minded professional psychologists, teachers with an interest in mental diagnosis, and people taught psychometry as office assistants of physicians are taught to do clinical tests, but we see psychiatrists also handing out opinions that concern mental structure and function in just these ludicrously simple terms. There is a great temptation to leave the paths of psychology, even of differential psychology, which are hard to follow; there is evident willingness to disregard many factors (such as the effect of attitude of mind and specialized powers and functionings) which really make the interpretation of tests difficult—and all for a scheme of mentality evaluation that is a flimsy foundation for the details of a superstructure of practical adjustments.[1]

Of course, the question must frequently arise, who is the proper or properly trained person to deal with given problem individuals, especially with children, with whom most of the work in practical psychology is done and to which sphere medico-psychology particularly desires to extend itself. In out-and-out cases of mental disease, with all the possibilities that we hope may develop in medical treatment, the rôle of the psychologist is subservient. But such cases are very rare in childhood. With mental defect—as witness the work in special school classes and even the only really therapeutic work in institutions for the feebleminded—the psychological diagnostician and psychologically trained educator have the

1 One might wonder whether the statistical aspects of psychological work which have been recently so much to the front and which of course are of tremendous value for establishing sound objective standards for individuals and groups are not responsible for the feeling that there is some great value in placing a number, an "I. Q.", after a person's name.

right to take a high place. Progressive physicians, as heads of institutions, have had to school themselves in these matters.

Out in the field it is generally found much easier to get a good physical report as diagnostic aid than it is to get well done the prolonged study of mentality that is necessary, for all except low-grade defectives, in order to institute good therapeutic and ameliorative effort. That in these matters it should be suggested that the physician ought to be the only one to deal authoritatively with the individual or that adjustments should be carried out under direction of the psychiatrist alone is strange indeed. Is this idea not based merely on precedent? We see no other reason for it. Ruling out physical troubles and mental disease, the psychiatrist has no special contribution to make, and in many cases where there are factors of physical irregularities and minor psychotic conditions the possible special adjustments are so primarily educational and psychological that at least there should be thorough coöperation and equal responsibility, rather than subserviency of either psychologist or psychiatrist.

It may be that psychologists adequately trained to grasp the possibilities of these fields of applied psychology are still so rare that they have been able to command as yet insufficient respect in the minds of psychiatrists. But with the rapid growth nowadays in numbers and in intensity of training, there is much more chance of the equality that is fair to the sciences, to the workers, and to the problem under consideration. Further development of the science of psychology itself will tend to ennoble the work of the psychological practitioner.

And when it comes to what is called psychoanalysis—meaning by this no special cult—it is an open question whether psychologists handling certain problems not requiring treatment as diseases may not do just as well in practice as psychiatrists. At least they are likely to take more into account certain fundamentals of the personal equipment, differences in talents, habit formation, and reaction types, which are vastly important, side by side with the fact of repressions, conflicts, complexes, inhibitions, and so on. The strange phenomenon of all sorts of people entering this enticing field of meddling with other people's minds—journalists and various kinds of laymen as well as quite unequipped physicians and psychol-

ogists—calls for the condemnation that only something like an adequate supply of competent psychiatrists and psychologists can make strong enough.

Many more considerations might be focused upon the cardinal points of our discussion—namely, the growth of a strong practical psychological science and the relations of psychologists and psychiatrists. But the upshot of it all seems to be as follows:

Psychiatrists should realize that:

1. The facts concerning abilities, general or special, belong to quite a different province from the facts concerning mental balance or mental disease, and one does not invalidate the other. There is a distinction, thus, between capacity or structure and dynamics or function.

2. The determination of capacities, which has a technique all its own, requiring special training, and the proper use of the results of psychological tests, means much more than simply following a set of directions. It demands interpretations based upon sound knowledge of general and particularly of educational psychology.

3. There is much experimentation going on in the field of psychology and there is a constantly accumulating body of literature and of new tests, many of which are of value. To keep up with this is no small undertaking.

4. There are many problems of poorly adjusted individuals which are much more truly psychological than psychiatric—they involve not only diagnoses, but also adjustments to school and vocational life, both of which are distinctly beyond the ordinary working considerations of the psychiatrist.

5. There is no reason why the well-trained psychologist is not capable of giving valuable testimony concerning mentally defective persons, even when commitment is in question, if diagnoses of possible physical and mental disease are accounted for. Defectives are not mentally diseased in the ordinary sense. On the other hand, the psychiatrist in many quarters is not even familiar with the critical methods of determining special mental defects or the best terminology in use.

Psychologists should realize that:

1. Problems of mental capacities cannot properly be answered without diagnosis of possible physical and mental disease.

2. All problems of the psychoses and neuroses require special training for recognition, study, and treatment. The psychologist having little knowledge of them, coöperation with the psychiatrist is indispensable for him; otherwise he is liable to do harm.

3. The psychologist who is not interested in or who is unfamiliar with the dynamic phases of mental life—special interests, effects of experiences, repressions, "driving forces" —is totally unequipped to study problems of maladjustment.

4. At least until we have better means of objective measurement for emotions and personality traits, these must be evaluated in descriptive terms and this up to the present has been better done by psychiatrists than by psychologists.

5. Many psychologists in practice are unfamiliar with the best even in their own field, of much that has been developed by experimental methods in the field of applied psychology.

Both psychiatrists and psychologists should realize that:

1. There is vastly more to be learned both in applied normal and abnormal psychology.

2. Each must learn to appreciate the other's field. There is no rational opposition or conflict; the work of each is complementary to the other.

3. Adequate training in both fields is impracticable for nearly all and hence there should be good teamwork for the sake of answering the specific problems of the individual and for advancement of the science. When it comes to case studies, both psychiatrist and psychologist should sit in conference.

4. As it stands now, psychiatrists are more accustomed to the use of descriptive terms. Psychologists are at present finding themselves able to develop more objective methods. But neither invalidates the work of the other. The effort on the part of each should be toward the establishment of objective standards which are the only criteria of a well-established science.

5. The wonderfully promising trend of to-day is toward betterment of human lives through constructive and even reconstructive work with children. Perhaps more than other therapies, there is possible educational therapy by wise adjustments during school age. For this is demanded a consideration of intricacies which call into play the best that normal, educational, and abnormal psychology have to give.

I am not sure that I am making friends in either camp by these didactics, but I have found myself really appalled by the psychometrist who passes out far-reaching judgments upon the individual from the standpoint of a few mental tests inadequately interpreted, by the psychologist who offers diagnosis, prognosis, and definite advice based upon a cursory psychological examination without any deep consideration of the physical, personality, or even social features of the case. And I am equally appalled by the psychiatrist or neurologist who renders a diagnosis of mental capacities, perhaps announcing mental defect, or who gives advice concerning specific educational and social needs, without consultation involving report on any sufficient range of mental tests, or even without any careful study of mental capacities at all.

It is with thought for sound progress in the several fields of the science of mind rather than to interrupt recent contentions that one asks this fair consideration of several phases of the work of to-day in psychiatry and applied psychology. Warmth of feeling not infrequently leads to fine exertion in competitive effort. We may benefit by many thus incited possible developments in our knowledge of mental life.

But on the whole it will probably be through the rivalries and finer criticisms of good-fellowship, particularly not through complacencies and feelings of finality in one's own point of view, that the best progress will be made. It is in thought of such pulling together that one may be allowed a beatific vision of vast benefits accruing through better understandings and realizations of man's mental potentials.

THE NEXT STEP IN THE MENTAL-HYGIENE MOVEMENT

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THE mental-hygiene movement has made such splendid progress during the short period of the past fifteen years that it is wise now to plan carefully for the future. There is so much that might be done that there is great danger of dissipating effort along too many channels instead of concentrating it at a few stragetic points.

It would be easy to give a general answer to the question: What are the immediate objectives in mental hygiene, the most promising fields in which to work, and the best methods to be employed? But it is not easy to choose the specific problems best worth while just now. As one interested, not in neuropsychiatry, but in the broader field of internal medicine—which includes practically all the problems of neuropsychiatry while they are still very indefinite and yet are more easily handled than they will be later when they clearly belong to the specialists—we would answer as follows: Just as physical hygiene, to speak accurately, is not an independent subject, but rather the reflex of general medicine—in much the same sense that the answer to a mathematical problem owes its value to the accuracy with which the various steps of the problem have been taken—so mental hygiene is hygiene only if it represents the logical conclusions of pathological psychology and neuropsychiatry. You cannot, short-circuiting these, arrive directly at mental hygiene. Of course we are speaking now of preventive medicine with regard to mental disease and defectiveness. This it is that also separates the wheat from the chaff of that great mass of confused ideas gained from experience, tradition, or superstition that have formed our rules of living. To give a concrete example of the above idea, and one better understood by laymen, we would say that the immediate object of the societies for mental hygiene should be now, as in the past, the continued educa-

tion of the public until the "average citizen" sees clearly that mental disease is disease and that the patient is sick and needs a hospital and expert care and not a jail. Accomplish this, and the problems of mental hygiene will soon be answered. Fads ruled in physical hygiene until the "average citizen" was convinced that tuberculosis was spread by spitting, typhoid fever by water containing sewerage, yellow fever by mosquitoes, etc. After that, the problem of handling these diseases became much easier. Just so, fads and fancies, freak systems of education, Binet tests in the hands of enthusiastic psychologists, and unorthodox religions, will dominate the so-called mental-hygiene field until mental diseases and defects are better understood by the public; and this means a campaign of education by expert neuropsychiatrists, the formation of more societies, more public meetings, and more popular literature, but all under expert supervision.

One of the chief reasons why we should begin and continue our campaign with the public is that the difficulties to be overcome are, both as regards their origin and their final solution, social in character. This will be evident if we remember that for the present unfortunate attitude of the "average citizen" toward mental defectives the average citizens themselves have been to blame. The extensive hospitalization of mental patients far antedates that of medical and surgical cases. In this hospitalization the safety of the public alone was considered, certainly not the welfare of the patients. So awful was their plight in state institutions, once these institutions had fallen into the hands of politicians, that stringent laws were soon enacted to prevent the unnecessary incarceration in these asylums of any "free citizen".[1] One result of this is that the term "insanity" is a legal and a social rather than a medical term, one that our medical students are taught to avoid, since

[1] See *The Don Quixote of Psychiatry*, by Victor Robinson. New York: Historico-Medical Press, 1919. 339 p. Except in possibly a few of the less progressive states, no such conditions now exist. Politics is still a blighting influence in some state-hospital systems; in the more progressive states, the influence of the politician is gone. The tendency throughout the country is to remove the state hospitals from political control and to place them in the hands of medical men specially trained in the diagnosis and treatment of nervous and mental disease. With the development of hospitals along these lines, the laws restricting admission are being repealed and laws encouraging and permitting voluntary and temporary-care admission enacted.

the courts alone determine insanity, not the doctors. The term insanity really implies only that the mental condition of the person affected is such that it would be considered no injustice to deprive him of liberty or the control of his property. We doctors are not allowed to decide this; we merely convince a suitable court official and he, if he is convinced, commits the patient. If, later, doubt concerning the insanity of a committed person should arise, the question will be decided by a jury of twelve laymen. The inevitable result has been that commitment is a late resort for conditions believed to be incurable, and that the public considers the stigma of commitment of necessity a great social injury.

During the past twenty years the progress made in neuropsychiatry is astonishing. We all agree that mental disease is disease; that the mental patient is a sick man, who deserves as much consideration and as little disgrace as the man ill with typhoid fever. He needs a hospital, not a jail; he needs real treatment for his illness by experts, trained nurses, and attendants; he needs hospital care, not merely bars, bed, and bad food. He should be grouped with other patients according to the actual treatment he is to receive and not, as at present, with the "quiet" or "excited", the "clean" or the "dirty".

But how can we "get this across" to the public and through them to the state legislatures? At first thought, one will say that the responsibility should rest with the general practitioners of medicine. They, in close touch with the families of their patients, should be able to see the first evidences of troubles that for years may not be conspicuous to others; they can advise, prevent, meet troubles while advice is of value and prevention and treatment are possible. The general practitioner could perhaps have done this during the past generation, had he had the information that we now have, but he never has had it and the chances are that he never will. These subjects were not taught in medical schools twenty years ago and the chances are that in the future they will be taught less than now during the undergraduate years.

Neuropsychiatry is an advanced subject suitable only for a postgraduate course, and postgraduate students do not intend to become general practitioners. The real trouble is that

the earlier the case, the more difficult is diagnosis and the greater need is there for an expert. Better that the specialist refer such cases back to general practitioners with the problem outlined for them rather than vice versa. To-day, thanks in part to the societies of mental hygiene, many laymen go direct to the consultant whom they—not the general practitioners—choose, and we imagine that more and more will do this.

Let us continue this discussion concerning the general practitioners further. Could societies of mental hygiene, did they so desire, bring such pressure to bear on medical faculties that more neuropsychiatry would be taught during the undergraduate years? The modern reformer evidently believes that legislation could make even an intemperate pedagogy good. Doubtless more and better neuropsychiatry could be taught than is now, but the chances are that the one result of the reforms in medical education now pending will be to decrease rather than to increase the amount of neuropsychiatry now prescribed for undergraduate medical students. This is inevitable. Our medical faculties must require less in order to teach better. The problem of the undergraduate medical course is to lay a solid scientific foundation for the student's future professional career, and four years are none too long in which to train the student well in general medicine and surgery; and only he who is well trained in general medicine has any business to begin the study of neuropsychiatry. The result is that not only neuropsychiatry, but also other specialties necessary for an efficient knowledge of neuropsychiatry—pediatrics, ophthalmology, etc.—will be pushed out of the four-year course and into the postgraduate years. But, insist our reformers, add a required fifth year to the medical course. Yes, we expect to do this some day, but such a year must in large degree be a year of elected specialization, and the chances are that no more will elect nervous and mental diseases than now follow this subject in postgraduate schools.

But, some might still say, why discuss neuropsychiatry? Our interest is in mental hygiene; at least more mental hygiene might be taught the medical students? It is of interest in this connection that there has long been in progress a discussion as to why our medical schools teach during

the undergraduate years so little physical hygiene, a much older subject. The argument used in the one case will fit the other, and is, briefly, this: While the well-established truths of hygiene can and should be understood and practiced, not only by doctors, but by every intelligent citizen—who, although quite ignorant of the evidence that supports these truths, nevertheless can see reason in them and will accept them on faith as empirical knowledge—yet hygiene as a conquering science can be developed only by those who approach it by mastering the sciences of which it is the logical conclusion. Hygiene is the final and perfect fruit of the medical tree. The ability to teach others accurately how to keep well is possible only to the man who first understands well those diseases which endanger his well-being. There is no short cut to hygiene. Show us an apple that has been produced independent of an apple tree and we will grant the possibility of a true mental hygiene that does not spring from a clear understanding of neuropsychiatry; and this in its turn is the fruit of general medicine. Of course this body of truth, once developed, may be accepted as a finished product that bears no sign of its origin. Even the members of religious sects that are hostile to the medical profession accept and practice very accurately the tenets of advanced hygiene—practically all of which came directly or indirectly from medical-school laboratories—evidently believing that since no mention is made in them of illness or disease, they may hold to the one and despise that which produced it.

But what are we driving at? Merely this: that the mental-hygiene movement should be directed only by expert neuropsychiatrists, and that the public must be educated to accept and to support these leaders. We are not afraid of the amateur who knows that his ideas are borrowed, but we are of the man with a little knowledge who poses as an expert. The serious question in the field of mental hygiene to-day is, Who are the experts? It is to the great credit of The National Committee for Mental Hygiene that they have chosen as their executive officers only neuropsychiatrists of splendid training and national reputation. Must not state societies for mental hygiene do the same? It is the state society that influences the state legislature.

We emphasize this, for we feel that a tragedy is pending. There are a large number of psychologists, of doctors (also masters and mere bachelors) of philosophy who, armed with the Binet test and a brief, superficial experience in hospitals and dispensaries for mental cases, are posing as specialists in mental hygiene; there are too many social workers who are specializing in this field who feel that they have "a mission"; there are too many faddists, quacks, and psychopaths who are literally wallowing in these ideas. All of these workers could prove very useful; all may be necessary; but only if they consent to work under the expert direction of the one whose ideas of mental hygiene rest on expert knowledge of neuropsychiatry and this on general medicine. There are no short cuts into leadership in this field, certainly not through psychology, sociology, or nursing.

What, then, is the next task of the mental-hygiene societies? It is, we believe, the careful selection and adequate support of experts connected with each state society. Adequate support means that these experts must have control of adequately supported psychopathic dispensaries, hospitals, or both, where as many as possible of the early or suspected mental cases may be studied and treated, and that the society must use its influence to secure the acceptance of these experts as authorities by the public and as directors of their work by the less well trained.

NERVOUSNESS: ITS CAUSE AND PREVENTION

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MUCH confusion has arisen in the language that deals with mental phenomena, especially during the last few years, so that before plunging into the subject of nervousness, I wish to define very briefly in just what sense I use certain much used and abused terms.

In the first place, the term psychology is often given, at least by implication, many mysterious and confusing meanings. This is not surprising when one realizes that it is only during the last century that psychology has gradually emerged from the status of a psuedo-science, a sort of unimportant tail of metaphysics, into recognition for itself. In our generation its terminology has been mutilated and the pieces appropriated by dozens of semi-religious, semi-philosophical cults, false healing systems, and well meant, but misguided floods of pseudo-scientific popular books, dealing with everything that has for the public the least element of mystery in it, from the action of the digestive organs to spiritism.

Briefly, psychology is only a sort of inclusive physiology. It deals with human behavior, with the response of man, the wise animal, *homo sapiens*, to his environment. Just as physiology deals with the reactions of his separate organs and groups of organs to their extrinsic and intrinsic environment, so psychology deals with the response to environment of man as a whole. The object of human psychology is plainly, then, to interpret human behavior and finally to predict what that behavior will be under given circumstances.

Mental hygiene may be considered a subdivision of psychology, one of its medical branches. To be more definite, it is the psychological branch of preventive medicine. It concerns itself with the ways and means, the rules and regulations, necessary to normal behavior—that is, to normal response of the individual to his surroundings.

Finally, to avoid confusion, let us assume a definite meaning for *environment*. Let this term include everything not included under the term individual. In short, it is the world in which the individual "lives, moves, and has his being". It has its physical as well as its mental aspects. To both of these aspects it is the individual's problem to adjust himself. The physical elements of environment, such as food, clothing, and factors tending to physical violence and disease, are the business of physiology, of physiological medicine, of preventive and physical hygiene, and are not, therefore, germane to our present subject. The mental elements of the environment, on the other hand, which are essentially the social elements, are very much our present concern. These are the elements that are definitely and specifically the business of mental hygiene.

The social aspects are *par excellence* those to which man as a whole reacts in terms of behavior. There are, in the first place, things or situations that seem to threaten or protect the integrity of his life as a whole, and that are to him markedly agreeable or disagreeable. The outstandingly important situations are, of course, made up of other people to whose lives he has to adapt himself, and who, on the other hand, are adapting themselves to him. To insure adequate and skillful adjustment to these primarily social aspects of his surroundings, to prevent the accidents and illnesses peculiar to maladjustment—in short, to help the individual to initiate and to maintain habits of normal and effective response—is the primary object of this psychological branch of preventive medicine called mental hygiene.

Among the most frequent and the most commonly misunderstood results of a poor adjustment of man to his environment is the condition that we call "nervousness". Simply through applying a little of the knowledge already formulated by mental hygiene, a great many, probably all, cases of "nervous breakdown" could be avoided. To cure this condition when once it is established is the concern of a special branch of medicine. This obviously requires a knowledge of the nature of the disorder on the part of the physician. But it is not quite so obvious that a similar, though far less extensive, knowledge on the part of the prospective patient himself is

required to prevent, and *will* prevent, such a condition from developing. This knowledge fortunately need not be as full or as detailed as that required of the physician to cure; and, equally fortunately, it is true that such sufficient knowledge exists, and furthermore that it is available to any one of moderate education and intelligence. It only needs adoption by the thinking public, especially by parents, to cut down the incidence of nervousness to an enormous degree.

Mental hygiene is as yet very young, but as it grows older, it will grow wiser, it will offer more and more of its knowledge in usable form, and there will be less and less necessity for nervousness, fewer and fewer nervous breakdowns. Even now it offers enough to enable us to say that nervous breakdowns are not only curable, but are distinctly *preventable* disorders.

Now as to nervousness itself, as I have already intimated, this condition is the result of imperfect response on the part of the victim to the social aspects of his surroundings. I now wish to add most emphatically that "nervousness" is not a *disease*, but a *disorder*. It is not a disease of the nerves or brain or of any other part of the body. It is not "auto-intoxication". It is not "weakness of the nerves", or exhaustion, or fatigue, nor is it a perquisite of the idle rich. It is none of these things. In other words, I want to make it quite clear that it is purely and simply the result of maladjustment on the part of an otherwise perfectly sound, essentially normal person, and that therefore it is both curable and *avoidable*.

The mentally and physically unfit obviously cannot respond normally to their surroundings. They are *inadequate*. They constitute an entirely different problem. In them we often find an exhibition of wonderful courage, resulting often in the most glorious victories—the triumphs of the handicapped. Appealing as these cases are, we must leave them to another chapter of the subject, for just now we are dealing only with nervousness, and this is not inadequacy, but inefficiency. Our problem is the most hopeful problem of all, for we have the splendid prospect of complete cure, of absolute prevention of future failures of adjustment, of the maintenance of complete usefulness, of the saving of a vast amount of misery and suf-

fering, not to speak of thousands of dollars' worth of wasted energy and talent; for we are dealing with good, sound, undamaged material, handicapped by mismanagement only.

Nervousness is largely a personal problem, a question of personal reactions, and the answer can best be summarized in the phrase, "Know thyself." There is no mystical implication in this phrase as I use it. It means simply, definitely, and specifically that self-knowledge psychologically and ethically is the best assurance against nervous breakdowns. Some general impersonal understanding of normal psychology—in short, of human behavior as a whole—is manifestly the necessary foundation for this essential self-knowledge, and it is likewise the basis of mental hygiene.

Types of Response

Human psychology, as I have already said, resolves itself into a study of the responses of man *as a whole* to his environment. Roughly speaking, there are three types or kinds of response into which human behavior can be divided—reflex, instinctive, and acquired.

In the first place, each one of us is born with a psycho-physical apparatus which responds in its various parts reflexly to changes in its surroundings. A reflex has to do with the adjustment of a part of the body to some stimulus. For instance, let an irritating substance be applied to the mucous membrane of the nose. It responds reflexly, and the response is a sneeze. Various organs and groups of organs in our bodies respond similarly by change of function to the varying stimuli that are brought in contact with them. The stomach responds to the presence of food, and varies its function according to the nature of the food present. The pupil of the eye contracts to the stimulus of bright light and dilates in the dark. The respiratory and circulatory organs respond reflexly to the quality of the air we breathe, on the one hand, and the varying demands of the body for oxygen on the other.

But the human apparatus has other inherent dynamic tendencies, which are, to all intents and purposes, highly compounded reflexes involving not parts of the body, but the whole individual. When these are set in motion by the appro-

priate stimuli, the whole individual responds as a unit, and this we call instinctive action. Instinctive action is always accompanied by its appropriate emotion. Indeed an emotion is an intrinsic and inseparable part of its instinct. Conversely, one may say that an instinct depends absolutely on its emotion for its dynamic force. An instinct is no more and no less than an inborn tendency to react in a certain predetermined manner to certain conditions or stimuli. For example, an infant, if hungry, reacts in a certain predetermined, characteristic way in response to food; also, if the desire for food is frustrated, we can safely predict that he will react instinctively in another perfectly specific and definite manner. One instinctive reaction being frustrated, another, usually that of pugnacity, takes its place; much energy is mobilized and expressed, and in the expression we recognize that instinct's own appropriate emotion—in this case, rage.

As another example, consider what happens extrinsically and intrinsically when the cat sees her hereditary enemy, the dog. The response is immediate, specific, and effectual. She presents a picture of mobilized energy. The mobilization is furthermore absolutely appropriate for the purpose—namely, defense or escape. The extrinsic signs of this status are stiffened muscles, rigid legs, arched back, erect tail, and bristling hair. Intrinsically, there are other signs. The heart is beating rapidly, sending a greatly increased amount of blood to the muscles and to all other organs of locomotion. That blood furthermore carries to the motor apparatus increased quantities of readily oxidizable material due to the action of the internal, so-called ductless glands. The digestive organs, not being needed for the emergency, are in a state of temporary paralysis—put temporarily out of business, so to speak. All of these internal as well as external changes are part and parcel of the emotion of fear. The cat undoubtedly feels the emotion as an irresistible impulse that with remarkable swiftness impels her to escape. Presumably without thought, as mechanically as a gun is discharged by a pull on the trigger, the cat at the sight of the dog runs. Should she meet an unclimbable fence, the instinct of escape will immediately be replaced by the instinct of pugnacity and quite as inevitably will she turn with rage to fight her pursuer.

Thus, if one studies the behavior of animals, one sees instinctive action in its pure, unaltered form, especially in wild animals. For instance, a loud noise to most animals is the adequate stimulus to set in motion the instinct of escape, and the emotion fear, which is an essential part of this instinct, literally lends wings to the animal's flight.

The third variety of action in human behavior is that of acquired modes of response. These are largely modifications of instinctive reactions. These modifications are brought about by training the intelligence and will, which are as conspicuous by their absence among animals as they are by their presence in man.

For instance, we *learn*—that is, we acquire—the habit of responding in certain conventional ways to the presence of tempting viands. If acting instinctively and without acquired control, we should respond to the smell and sight of food by simply devouring it, and, if interfered with, we should as simply fly into a rage and fight. Furthermore, we learn to modify our instinctive actions by intelligent control, not only for the purpose of substituting some opposite action more appropriate to the occasion—such as doing the right and intelligent thing even though fear, let us say, bids us run away—but we train the very instincts themselves to greater perfection of action. We may become skillful fighters if need arise, as well as self-forgetful and reasonably self-sacrificing citizens.

There are two important elements that profoundly affect human behavior and that vary greatly in strength in any given individual. The first of these is *temperament*. This is a qualifying characteristic. Briefly described, it is a tendency to be oversensitive or undersensitive to such items in the environment as usually produce in any one markedly painful or markedly pleasurable sensations and emotions. Oversensitiveness to one's own emotions and sensations naturally leads to overvaluation of their significance and importance, which of course directly affects behavior. If a sensation or an emotion is valued as a very disagreeable one, and almost intolerable in itself, one's thoughts and efforts are naturally bent on getting rid of it or modifying it. If, for instance, one is oversensi-

tive to the disagreeableness of fear and fear itself is therefore overvalued, it is treated as an item to be avoided at all costs, and life is accordingly modified, consciously or unconsciously. The other element, which is difficult to define, and which I shall not even attempt to describe, but which must be reckoned with as of the greatest importance in human behavior, is that which we call *spiritual*. It expresses itself more or less concretely in ideals. These ideals are frequently in conflict with our instinctive demands, and this conflict, through its interference with the realization of ideals through action, constitutes the fundamental problem of human conduct.

On the one hand, animals, without the power of choice, presumably without spiritual impulses, are impelled in any situation by whatever happens to be the instinct or instincts aroused by the then present environmental stimuli. They do not preside over the conflict of instincts, nor, presumably, is there any conflict between the strongest instinctive impulse and some ideal demand. They are frankly and simply subject to their instincts and their behavior is proportionately simple and direct. A cat, when she sees her enemy, the dog, feels the emotion of fear, which puts all of her machinery of flight into action. Unless the expression of this instinct is blocked by an insuperable obstacle, her flight continues until the emotional force is exhausted. If the flight is blocked, the instinct of escape is immediately replaced by the newly aroused instinct of pugnacity, and she quite as inevitably fights. But all of this presumably without choice or without reason.

On the other hand, the human being presides over the conflict of his own instincts, felt by him as a conflict of emotions. He presides over this conflict with intelligence and with a consciousness of the power and necessity of choice. This would be a comparatively simple process if it consisted merely of choosing which instinct was to have expression; or if it were only a matter of choosing which was the most expedient manner of obeying that instinct—whether hiding, running, or "playing possum" would satisfy the situation. The strongest instinct would always win, and it would be merely a matter of adding intelligent planning to instinctive action to make that action more effective. However, fortunately or unfor-

tunately, the other great element that I mentioned comes in with its demands—namely, the spiritual. The ideal of service and self-sacrifice may demand of a man whose instincts would drive him simply and quickly away from danger that he shall stand fast and neither hide nor "play possum", but sacrifice himself without recompense of any sort, except the spiritual, even to complete self-destruction. It is when intelligence and will are used to realize an ideal through an action which is contrary to instinctive demands that animal behavior rises to the dignity of human conduct. To keep instinctive forces under the intelligent control of the will, in order to realize through these very forces our ideals—that is to live a civilized life, a happy life, and furthermore a healthy life.

Environmental Difficulties

The inherent instinctive outfit of man, it is safe to assume, has been very little altered since history began. He is very much the same animal as he has always been. He has the same reflexes, the same instincts, the same primary emotions, and probably very much the same intelligence as he has always had. In short, during the history of civilization his original outfit during his lifetime, all of these fundamental inherent elements, have presumably been changed but little. But his environment has changed enormously and with great rapidity. The mode of life in a single generation has often changed from that of primitive man fighting for survival in a frontier wilderness to the highly civilized and complex existence of city life.

The physical elements of man's environment, it is true, have changed greatly during the progress of history, but these changes are not of a kind to tax his adaptation severely. To be free from the hardships of hunger and cold and exhaustion, to be warm, well-fed, and well housed and no longer subject to exhausting physical strains, requires a very slight and a very simple sort of adaptation. But the social complexity, the multiplication of tempting opportunities that such physical changes imply, these do tax his power of intelligent adaptation. The social factors have undergone an enormous change, from primitive simplicity to their present complexity

and rapidity, and it is this rather than the physical change that makes adaptation difficult. Physical comfort and safety, it would seem, have been won through multiplying mental and moral risks.

Ease of communication by rapid transit, telephone, telegraph, labor-saving devices, all sorts of time and space annihilators, are the things that, in my opinion, are largely responsible for our difficulties of adjustment. These labor- and time-saving devices are highly beneficial in themselves—as labor-saving devices. They broaden one's horizon, multiply one's opportunities, and are capable of saving much energy and of conserving leisure, if wisely used. Only when they are used as leisure killers, only when we allow them to tempt us into trying to do three things at once, making two blades of grass grow where only one grew before, only when we use them to accomplish the impossible, to crowd a life's work into a few years, are they harmful—but then they become the very instruments of the devil.

Think of the difference between the mental processes of the modern business man and those of his old-fashioned prototype of the nineteenth century. In that golden and primitive past, whole days would be consumed in the completion of an only moderately important business transaction. A good bit of friendly intercourse and social entertainment, much that was gracious in manner and speech, form to the point of elaboration, were considered assets in those courtly olden days. Such time-consuming processes were part and parcel of the old-time merchant's business activity. There probably was no such thing as the chronically tired business man, for everything he did was comfortably packed about and upholstered with little pleasant, healthful things that took time.

Compare the old-fashioned picture with what we are familiar with in the modern business man's office. He arrives by rapid transit, elevated, automobile, or what-not, or even by airplane, at a huge, noisy structure which he enters in company with a crowded, hurrying stream of other preoccupied speed maniacs. Having taken not more than perhaps a hundred steps since breakfast, he is shot upward at a terrific rate, probably in an express elevator, and is hastily ejected at the

twentieth story within a half-dozen steps of his office. There, if his organization is "up-to-date", he will find things already started, perhaps going full tilt. His mail is already opened, even sorted for him. He does not waste the fraction of a minute between shedding his hat and coat and beginning to dictate his replies and give his orders. Even while dictating, he will hold not one, but several, conversations of importance on the telephone; and before finishing these, it is more than likely that he will be starting a third activity of some sort, such as interviewing a client. In short, he does probably in an hour of what to him is an ordinary business day as much as the old-fashioned chap did in a week. Does he leave the office any earlier because of this wonderful speed? Does he gain leisure? No indeed; he stays just as long or longer, but he makes more money. It hardly needs scientific argument to prove which type of life means longevity, let alone contentment, happiness, and health.

I do not mean to imply that the modern citizen is less intelligent or is less wise than his forefathers. On the contrary, I believe that the problem is far more hopeful, for I am sure that he is just as wise, just as intelligent, and has all the wisdom of his forefathers' accumulated experience to draw on, if only he would. But I think it is clear without argument that be he wiser or less wise, his modern environment calls for the exercise of greater wisdom, for greater adaptability, than were necessary a century or more ago. Obviously there is greater speed, greater emotional strain, a greater tendency to let quantity of effort spoil the quality of life. In short, the greater wealth of opportunity is fraught with the danger of a greatly increased temptation to unwisdom.

Difficulties of the Sensitive

Yet it is true that normal, evenly balanced people—that is, the great majority of people—can and do most successfully adapt themselves to these entirely extraordinary factors of modern life. But to the inherently oversensitive individuals, this present environment of ours offers increasingly tempting dangers and pitfalls. For the hypersensitive, more emotional person tends to *over*-react, especially to things that

normally produce markedly painful or markedly pleasurable emotions in most of us, and especially to avoid such things as produce markedly painful reactions. Thus the behavior of a certain minority of people tends to be impulsive, emotional, instinctive. It tends, therefore, to be unplanned, hurried, incomplete, and superficial and clashes with the strident, speedful world of the present. Instead of guiding themselves wisely among the environmental difficulties, they succumb to its temptations and dangers. These oversensitive and overemotional people tend to act according to how they feel and then to apply judgment and will only when it is practically too late.

Wishes and fears tend to distort thoughts. We all tend to believe rather what we wish were true than what is true. But when this characteristic is exaggerated, perhaps chiefly through lack of training, it obviously makes for poor adjustment to the world as it is, and maladjustment leads directly to malcontent. Malcontent frequently expresses itself in the pseudo-philosophies and cults that describe the world not as it is, but as they wish it were.

The nihilist and anarchist, the parlor Bolshevik, the cubist and the free-love doctrinaire, are examples of essentially maladjusted and discontented people. They imagine a world that in each case shall contain the element that they most crave personally, and a world, also, that shall be free from the obstacles to achievement and obstructions to self-expression which they have found most difficult and most annoying—a world of commerce without money, capital, or labor, without management or competition; a social world without laws or customs; a world, in short, without those restrictions and necessities to which they have found adjustment difficult, and which they wrongly blame for their own mediocrity or lack of success; a world where their weaknesses shall be assets, where their supposed strengths shall make them leaders without competition or effort.

These people are essentially neurasthenic—that is, they are nervous. If they could be given self-knowledge, it would cure all of them, and they would then find contentment and happiness in accepting their world as it is as the basic starting

point for good work, as the raw material out of which to forge success.

As an example of how ignorance of the essentials of a problem in personal adjustment leads to a poor solution, the war neurosis is most instructive. (This condition, by the way, is often misnamed "shell shock", for the shock of a nearby exploding shell is only very rarely associated with the beginning of the disorder.) A man, usually somewhat hypersensitive to his own emotions, often with an essentially timid personality, finds himself in a position of extreme danger, or if not actually in the position of danger, on his way toward it. His ideals of honor, of service, and of loyalty push him onward toward the goal from which his instinct of self-preservation, through the emotion of fear, is doing its best to hold him back. Through misconception he has learned to consider fear as synonymous with cowardice. His own essential self-esteem excludes cowardice from his idea of self. Indeed, as a matter of fact, he *knows* he is not a coward. Therefore, it is impossible for him, in the face of this prejudice, to recognize or acknowledge the presence of fear. Fear, however, is what every normal man must feel when in danger, and furthermore this emotion, like all emotions, is not just a mental state, but is actually also a bodily state, a state of mobilization of bodily forces, a state of preparation for immediate flight, and it has very marked and noticeable physical signs. Among these are a rapid and often irregular heart, tremor of the muscles, a dry mouth, and disturbances of the stomach and intestines. One man cannot help being disturbed by these physical disorders, which, largely because they are neither understood nor recognized, become exaggerated. They finally constitute a bodily condition which becomes the innocent focus of his fear. Fear of breaking down physically he can recognize and can acknowledge without prejudice to his character. He can with spiritual safety be afraid that his physical condition will interfere with his carrying out his ideal of service. In short, he can recognize a fear of failure from bodily causes over which he has no control, whereas, in his ignorance, he cannot acknowledge that he is afraid of being killed or horribly maimed. The emotional state becomes ever more tense, its physical symptoms more

marked, until they dominate the picture, and he is actually disabled by disordered or paralyzed bodily function. The deadlock of the conflict between his ideal of service and his instinct of escape is incidentally broken by the condition produced by the emotion, for that condition makes it physically impossible for him to go on, and much against his will he is *ordered* to the rear—a case of "shell shock".

Had he known that fear is the one occasion and the only occasion for courage, and that it is *not* synonymous with cowardice; had he had sufficient knowledge of his own psychology to recognize fear as part of the normal and universal reaction of any human being to danger and courage as the spirit in which one does things in the face of fear, his problem would have been a very simple one—namely, whether or not he could do his duty, even in spite of being filled with fear. He might have had, probably would have had, a short, but decisive moral struggle, but he would have brought his will to bear upon a clean-cut, soluble problem, and he would undoubtedly have gone through successfully, and been shot!

The same is exactly true of the more complicated neuroses of ordinary civil life. Knowledge of the factors of the problem of adjustment is the first step and the absolutely essential step toward a successful solution, and as in the war neuroses, given the requisite knowledge, we can be quite sure of finding the strong desire, the will to get well, ready to apply itself to the problem as soon as the latter can be made clear and definite.

Recognition of Elements in Childhood

To prevent the occurrence of "nervousness" is, then, obviously the problem involved in the prevention of maladjustment. Whether tender-mindedness is acquired by early contagion from nervous elders or by lack of training, as in the case of a spoiled child, or is partly inherited, may be left as an academic question. However this and other elements that make for nervousness may arise, it is the business of the mental hygienist to recognize these elements as early as may be, so that, being recognized, they may be trained from being liabilities to being assets. The time for this recognition and

training is in childhood, for it is then that the seed of nervousness is sown.

I believe that the following are the most important of these elements that tend toward nervousness, on the one hand, and are particularly amenable to training on the other.

The temperamental tendency toward oversensitiveness to the markedly painful or markedly pleasant emotions and sensations is perhaps the most common and fundamental element which, if unrecognized and uncorrected, makes for later nervous breakdowns. This element is recognizable even in the early months of life. Whether it be inherited in part or in whole or merely acquired by circumstances is not important to our present discussion. That it is recognizable in very young children is most important, for this fact presents one of the earliest and most hopeful opportunities for training.

All of us, especially when we are children, are sensitive to our own emotions to a greater or less extent and are especially appreciative of the pleasurable emotions. But a certain proportion of children are *over*sensitive to emotions, particularly to painful emotions. They give physical evidence of this extra sensibility by over-reacting physically to correction, disapproval, and punishment. They show the over-reaction most often not only in being over-prone to weep, but also in disturbances of digestion and circulation. They may lose their appetites, their bowels may become disturbed, or they may even react emotionally to painful situations by an attack of vomiting.

On the side of circulation, they are the children who blush and blanch easily. They may also show an overexcitability of their kidneys and sweat glands. In short, they perspire too easily under excitement, cry too easily, and likewise their overactive kidneys, under the same circumstances, may lead to one of the most embarrassing accidents of childhood. Too often this latter unavoidable accident meets with severe and unjust punishment.

On the mental side, they show a greater dependence than normal on praise and approval and especially an exaggerated sensitiveness to disapproval. They show the latter by avoiding conflict with authority as much as possible, either by ex-

aggeratedly good behavior or by deception and lying. Their repugnance to the disagreeable—whether it have to do with the touch of a disagreeable surface or substance or a disagreeable taste or with being too easily and too markedly influenced to avoidance of such things as may arouse in them a painful emotion, such as fear—is evident and conspicuous.

These signs of the oversensitive temperament, as I say, are easily recognized in early childhood and call for definite training. Usually they are noticed, but rarely are they understood and often quite the wrong training is applied. Punishments are made too drastic, or the parents sedulously plan to avoid all discipline wherever possible and so to arrange the child's environment as to avoid the production of fear or any other disagreeable reaction. Both of these extremes are apt to lead to the same result—namely, an increase in the sensitiveness, a further accentuation of the very handicap that they had intended to remove.

On the other hand, the training should have in view the distinct object of molding the sensitiveness itself into a useful force. The first steps of this training are to give the child a true valuation of tolerance of the disagreeable, and to help him to a realization of the naturalness and normality of the emotion of, let us say, fear, which only needs a little courage to combat it. At the same time, an appreciation of the necessity and importance of adapting himself to the needs of his playfellows can be aroused through stimulating his interest in team play, which makes a good basis for normal courage. For instance, instead of telling a child that he is silly to be afraid to go into the dark room, that there is nothing there to hurt him, that he *ought* not to be afraid, or that he is a baby to be afraid, he should be told that *of course* he is afraid, that lots of other children are afraid of the dark, even though there is nothing to be afraid of. He should be shown that being afraid is one of those disagreeable things that we can get over by not thinking too much of it, and that at all events he is of course going into the dark room to get the game or book he wants, because he wants it. It can thus be shown him by the actual demonstration of going into the dark room and getting the desired game in spite of f[illegible] in the first place, how harm-

less that little fear of his really is, and, in the second, how comparatively easy and fully worth while it was to get the game—a little victory, but lots of fun when won. Every effort should be made, in other words, to accentuate the importance and desirability, the satisfaction and fun, in free objective action *in spite* of rather than *because of* sensitiveness. Every effort should be made to make the interest in doing things and the results of doing things always stronger and more enticing than the abnormal and introspective interests that the child may have in his own emotional reactions.

Such training, for instance, is quite capable of turning timidity into habitual courage, sympathetic pain into the professional understanding and practical, purposive sympathy of the genuine physician or nurse. Such training can transmute sensitiveness to color or sensitiveness to sound into intelligent appreciation and thus make of it the professional understanding of the successful artist or musician. One can turn this sensitiveness by such training into useful, objective appreciation of the physical and social environment, including the needs of others. Thus a liability can be turned into an asset.

The second element making for nervousness, which is, as you will see, largely dependent on the first, is disturbance of the balance of instincts. By this I mean an over-prominence, an over-irritability of one or more of the instincts in relation to the others. Usually this also is recognizable in very early life and the temperamental sensitiveness just described is always associated with it. Indeed it is the instinctive force that gives sensitiveness specific form.

Usually the instincts of self-preservation, escape and pugnacity—one and sometimes both of them—with their respective emotions of fear and anger, are the moving forces in the second element making for maladaptation. This specific sort of sensitiveness is indeed easy to recognize at an early stage. Who cannot recognize even in infancy the markedly timid or the markedly pugnacious personality in a child? The timid, shrinking child and the irritable, pugnacious child, subject to fits of temper, are too well known both physically and mentally to need further description. The former, I think, is

more apt to be headed for nervousness than the latter, though even the latter, if he be of sensitive temperament, is a neurotic risk.

The training of this element, if not easy, is certainly plain. The child must be taught to acknowledge the presence of the emotion, whether it be anger or fear or whatever. He must learn to treat it not as an enemy, but as a natural part of himself. He must *not* be taught to deny its existence or to make believe through repression that it does not exist. He must be taught to say to himself, "I am mad, or I am afraid, *but* I can *do* as I choose", and he must be held responsible for that choice. Gradually his interest in growing up to be an effective actor, an effective performer of acts of which he approves, must be built up. Coincidentally, good-natured contempt for his own emotions should be established—that is, contempt for the painful element in emotion and sensation. To be a "good sport" rather than a slave of fear or anger must be made an understandable and furthermore an attractive proposition. To make discipline seem always to be self-discipline rather than superimposed I believe to be an important point. Punishment as far as possible, perhaps always, should be to the child an obviously inevitable result of his own action rather than the outgiving of the judgment, backed up by the power, of that superior being, his parent. The parent should stand to him rather as a wise friend whose judgment he believes in and wants to follow than as the strong arm that carries out a little understood law. I believe these rules hold good no matter what overactive instinct we are dealing with, whether it be the instinct of escape, of pugnacity, or even the sex instinct. Our object is to train the child to guide the energies and impulses supplied him by his instincts, not to deny or suppress them, and above all not to be subject or slave to them. In short, the object of training is to make a civilized citizen out of a little, perhaps overly strong, animal.

The third item in the personal equation which needs recognition and calls for training appears later in life than the first two. It has to do with difficulty in realization of the spiritual element where ideals are either unformed or fail in adequate expression because of instinctive or temperamental obstacles.

For lack of a better term, I will call this "character fault" or "weakness". The signs of this tendency are absent from the physical point of view, except, perhaps, in the matter of those indefinite signs of facial expression and form which we rightly or wrongly attribute to strength or weakness of character, such as the "square" jaw, the "loose" lip, or the "wavering" eye. The element, however, can be definitely recognized by a comparison of the individual's behavior with his professed ideals and by noting a prominent feature that is always there —namely, *unreliability*. People with sensitive temperaments and unbalance of instincts always remind me of an electrical apparatus that is suffering from a tendency to short circuit. A person with character faults, on the other hand, resembles an electrical apparatus in which the wires just fail to make connection and the current of energy from the ideal to the apparatus of expression fails to get through. They know theoretically what is right, they are not moral idiots, but they fail to make good their ideals in action with any reliability.

The training of this tendency takes perhaps more tact, more delicacy of touch, and more sympathy than do all the others, for it calls for practical moral training, and by this I do not mean continual punishments or old-fashioned "moral suasion"—though this no doubt has its place—or picturing in lurid colors the "way of the transgressor". It consists rather in showing the adolescent child how his technique has failed, just where a little determination would have made the connection; in showing the practical advantages of regularity, both physical and mental, the efficiencies to be attained by a planned life, the ease to be gained by the momentum of regular habits, and last, but not least, the fundamental necessity to him of contentment above comfort, of happiness above pleasure; and finally in proving that these can be attained only by running the ordinary ideals of life straight through the instinctive apparatus to practical, everyday action.

Irregular Development

There is a fourth type of disorder that tends to nervousness which is important enough to afford a separate classification. The human young, unlike the young of other animals,

tend to develop irregularly. The intellectual side of a child may develop far ahead of the physical and even of the moral. This irregularity is not hard to recognize, especially for the proud parent, who is only too ready to acknowledge precocity of intellect in his own offspring. Unfortunately, only too often the proud parent, instead of turning such a child's energies more toward the development of those elements that are lagging behind—namely, the physical—will in his pride and delight in the child's cleverness push his already over-developed intellect to further precocity. In extreme cases the "infant phenomenon" is developed, who rarely if ever escapes an even more serious breakdown than common nervousness. Obviously the training of such a child should be aimed toward balancing his development by increasing his physical strength and well-being. Out-of-door games and exercises and interest in nature studies should be emphasized, rather than progress in mathematics, woodcraft rather than Latin. All of this can be done without any undue neglect of the purely intellectual development. Indeed it would surely be just the right kind of intellectual development for the physically backward child to turn his interest and reasoning power toward the phenomena of nature and his own growing physical prowess.

When the physical development is obviously ahead of the intellectual, this is easily to be recognized by the fact that the child has to study harder and gets poorer results than the average—usually to the unreasonable despair of his parents. Then the intellectual and moral side of the individuality call for development, but this can be done only gradually, not suddenly. Regularity of life in these cases is particularly important. Such children should be taught to guide the instinctive forces into purposive channels by the gradual introduction of simple, objective, purposive mental effort in relation to outdoor play and exercise, of which such a child is probably already fond. More important even than constructive play is constructive work, both mental and manual, and for such children the educational value of physics, mathematics, and, above all, of manual training, cannot be overestimated. Gradually to stimulate interest in achievement, to arouse gradually curiosity in the "why" of the things in which the child up to then has merely taken animal pleasure,

by stimulating interest in nature and nature's laws, and gradually working through biology to other sciences, is to lead intellectual development on gently till it matches the physical.

When the moral element lags behind, the same method of treatment should be employed as I have roughly outlined as appropriate for character faults. But we should be especially careful not to harden by constant and severe disapproval. We should try in every way to accentuate our appreciation and approval wherever we can find even a slight excuse for it in something well done and for a good purpose. You can always depend upon it that the child will react toward and will be attracted to the pleasurable emotions aroused by approval and praise as readily, at least, as he reacts *away* from the pain of displeasure and disapproval. In short, we must show the child who is backward in moral development that it *pays to be good,* and to do this we must praise every good point; on the other hand, disapproval, when we show it, must be shown only for a purpose and not because we are angry. It is only through the most patient and sympathetic effort that we can hope to make social adaptation seem a worth-while process and a necessity to the morally backward child. To make moral response habitual and reliable must be not only a labor of love, but one of unwavering faith and patience.

Unfavorable Environmental Elements

Modern life, especially the life of the well-to-do, is in many ways poor training, very poor mental hygiene, for the growing child. It presents too much superimposed entertainment. This entertainment, furthermore, has excitement rather than healthful pleasure as its main objective. Movies and theater parties *might* be all very well, but are they? They *might* be opportunities for constructive and instructive play, innocent amusement, and interest, but usually they are not. In the first place, such entertainments are far too frequent in the average child's life, and in the second place, they result in nine cases out of ten not in interest, but in excitement. Coupled with dances lasting to all hours of the night, they constitute an active menace to the child's mental health. The result is that most melancholy sight of modern times—the over-old, blasé

youngster who demands that there shall and must be "something doing" every moment. Through no fault of his own, he has developed within him an abnormal appetite for excitement, on the one hand, and, on the other, a pretty complete ignorance of the real pleasures of play, and unless he is a very evenly balanced, stable individual he is fairly on his way to become a neurotic. Public playgrounds, child athletics, and games in which the real pleasure of play comes from the successful exercise of energy, make for health and stability and not only balance work, but keep the appetite for work, for achievement, alive; whereas movies and modern superimposed entertainment, with only excitement as an unacknowledged goal, make for unbalance, discontent, and nervousness.

A modern child, especially a girl, is dangerously apt to skip from the mental and social age of twelve almost overnight to that of eighteen. This forcing process of modern social life suddenly ejects her from innocent childhood into the status of a society woman. She skips and thus loses utterly those wonderful years of natural fun, of growth of interest, of development of character, of the gradual unfolding of the knowledge of life, those wonderful "teens", which should be lived joyously and as slowly as may be. These should be the years of the most valuable formative training, but too often nowadays are they exploded out of existence by the forced high tension of the modern régime. These years should be guarded, should be utilized for our children's gradual growth and development, and if they are so utilized, they will cheat the nerve specialist of many of his cases.

I have dealt with mental hygiene only where it touches my subject—"nervousness", its causes and prevention. I have spoken of the knowledge already existing, which, if applied, would in my opinion prevent nervousness. Much of this knowledge, you will see, is quite obvious, long known, not original or exciting. True, but that probably is the very reason why it has not been applied. No doubt much of it is too ordinary or too obvious to invite attention, and it has therefore been neglected.

Most often nervousness has its beginnings in childhood; therefore it is in childhood that preventive training should be applied. Obvious, but none the less true.

To summarize, the recognizable symptoms of potential nervousness are:

1. Sensitiveness to the disagreeable and painful.
2. Overbalance of one or more instincts.
3. Faults in application of intelligence and ideal to instinctive forces (character faults).
4. Unevenness in the relative development of the physical, mental, and moral sides during growth.

One or more of these is always the fundamental cause of that maladaptation called nervousness. It is obvious, I trust, that early recognition is not only necessary, but possible in all cases. Obvious or not, it is the truth.

If these tendencies should be and can be recognized, to overcome their influence it is only necessary to train the child accordingly, and this then becomes largely a matter of applying common sense to a clean-cut, formulated problem. To this end all of us, especially parents and teachers, need merely a working knowledge of everyday psychology. It is a simple matter to apply such knowledge in the form of mental hygiene, both to the up-bringing of our children and to the ordering of our own lives.

Prevention in Adult Life

To avoid "nervous breakdowns" in adult life it is necessary only to maintain one's mental and moral efficiency. This can be made a simple, straightforward matter by following a few more or less simple and common-sense rules. These rules can be readily deduced from everyday psychology and common experience. If adopted and applied steadily, they will prove beyond a doubt that "nervousness" can be avoided.

Here follow a few such practical suggestions, more or less formulated specifics against becoming "nervous".

1. Neither run away from emotions nor yet fight them. Accept them as the wellsprings of all action. They are your automatically mobilized energies, and you may, within very wide limits, do with them what you choose. You may furthermore do what you choose, again within broad limits, in the way, in the manner, in which you choose to do it. By doing what you choose, in the way you choose, you force these energies into the channels of your choice. It is like guiding spirited

horses—you guide, they obey, not their own impulses, but your will. A simple suggestion, but if followed, it leads one safely away from the dangers of sensitiveness and unbalance of instinct.

2. Be efficient in what you do. First approve the purpose of the act, then perform that act in a manner and with the means that are appropriate to its purpose. Efficiency or inefficiency is determined by the relation between effort expended and result obtained. Obviously the result must be worth the effort. Nothing is worth doing that is not worth doing *well*, but "well" must include not only the attainment of the gross end in view, but it must also mean attainment without waste of effort. Quality of effort appropriate to the end, skill rather than crude force, means efficiency. In short, do not drive your tacks with a sledge hammer. There is a better, less fatiguing way. Find out how easily you can do things well, and take pride in such skill.

3. Do one thing at a time. Only thus can you practice concentration. By concentration I do *not* mean that violent overdramatization of effort usually understood as concentration, but the gentle art of controlling the attention. This art consists almost entirely of many, oft-repeated, small acts of skillful selection. It is really no more than gently culling from the stream of thought that which is interesting and relevant to the object of the moment and discarding all else. Above all, it is not a violent, sustained moral effort.

4. Make clean-cut, practical decisions. To be clean-cut, they must deal with problems clearly stated and as free from emotional prejudice as may be. To be practical, they must deal with problems of present moment and relevancy, with probability rather than possibility, with the concrete rather than the vague. Finally, decisions must be valued not as irrevocable oaths or unretractable contracts, but as mere decisions, subject to change in the face of new facts or additional knowledge.

5. Do not accept hurry as a necessary part of modern life. If hurry in any given case becomes necessary, it has become so solely because there has been a direful lack of plan, or because tardiness and procrastination have spoiled the plan, or lastly because one has tried to crowd two or more things

into the temporal space of one. Quality of work, not quantity, spells success, and quality is destroyed by hurry.

6. The worst enemy of efficiency, as well as the best ally of nervousness, is worry. Worry is a complete circle of inefficient thought whirling about a pivot of fear. To avoid it, consider first whether the problem in hand is actually your business. If it is *not*, turn to something that is. If it is your business, decide next whether it be your business now. If it be your business and your business now, decide what is the wisest and most efficient thing to do about it. If you know, get busy and do it; if you do not know, if you lack knowledge, seek the knowledge you need and seek it now. Do these things, and in nine cases out of ten, anxiety will not degenerate into worry. If the actual probabilities are so very bad that intense anxiety is unavoidable, nevertheless, apply this mechanical rule, and then assert your faith and your courage: realize that success, for you as for others, is always approximation of the ideal; then rest your case on the determination that no matter how hard things may turn out to be, you will make the best of them, and more than that no man can do. In short, common sense can put worry out of the running in most cases, but always faith is essential to real victory.

7. Keep work, play, rest, and exercise in their proper relative proportions, not only in the space of decades, but year by year, month by month, week by week, and day by day. Keep these items separated. Work when you work, play when you play, and do nothing when you rest. Each item has its *daily* place, and a well-planned life is a life made up of well-planned days. Such a life absorbs emergencies without strain.

8. Shun the New England conscience. It is a form of egotism that makes a moral issue of every trivial thought or feeling. Its motive is self-defense, defense of self from the possibility of guilt or consciousness of moral error. It takes the adventure out of life and fills it instead with endless petty, safety-first devices, clogging its machinery and warping it out of true. To live fully and with reasonable ease, one must take one's own fundamental decency more or less for granted, and be willing to take at least ordinary chances of being wrong. Soul-harrowing analyses to prove one's moral impeccability are expressions of nothing better than worry about self, and the same rules apply to this sort of worry as to all other sorts.

9. Energy is often wasted by a peculiar process which many people seem to think necessary before they can do anything, especially anything that promises to be difficult. I refer to a sort of "getting up steam", a kind of moral mobilization, an attitude of "girding up the loins" mentally speaking, which is referred to by them as "making up their minds", or "getting ready" to do something. It is not a decision, but usually follows one as a sort of preliminary flourish before action. It is really only picking up a moral sledge hammer, and an imaginary one at that, when a practical decision has already cleared the way and nothing remains to be done save to begin immediate action. When a decision has been reached, when something has to be done, waste no time in mobilizing extra energy—just do it.

10. Lastly, to avoid breaks in character, breaks between your ideals and your everyday actions, recognize that your problem is fundamentally the same as every one else's, no matter what your particular job may be. This problem of ours, reduced to its common denominator, is to keep our ideals clear, to adopt purposes that shall serve these ideals, and lastly to make our ideals live in practical, purposive, everyday action. To do this, it is first necessary to accept the material of life as good enough for us, as definitely *our* material, awaiting only our workmanship to be forged into success. This should be our method of making our dreams come true, of living up to our great illusion. Therefore, waste no time in kicking against the pricks. The "divine unrest" of ambition is a noble spur to better action, but the restlessness of discontent is a miserable state of misunderstanding. Beware the contrary currents of anger, fear, and pride, but turn the strength of these currents into the channels of your purposes. Do not criticize your part in the play; study it, understand it, and then *play* it, sick or well, rich or poor, with *faith*, with courage, and with proper *grace*.

To follow these rules absolutely and to the letter is certainly somewhat beyond the power of human frailty, but to follow the spirit, to steer one's course by some such compass, is both possible and practical. Thus and only thus can one maintain a good, safe offing from the shoals and reefs of nervousness.

THE SOCIAL SIGNIFICANCE OF DEMENTIA PRAECOX*

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MENTAL diseases have been divided into certain large and more or less definite groups, on the basis of their symptoms, course, causes, and other important characteristics. These groups are not always enclosed by rigid boundaries, but, like some of the main groups of general diseases, often overlap, and an individual patient who seems at first to belong in one group is not infrequently found later to belong in another. One of these groups of mental diseases is dementia praecox. The name suggests two of its chief characteristics —tendency toward mental deterioration and relatively early age of onset. Allowing wide latitude for individual medical opinion, different clinical aspects presented by the same patient in the different phases of the disease, and a fairly high proportion of atypical cases, patients with dementia praecox represent a section of the population of hospitals for mental diseases definite enough, large enough, and important enough to make some facts regarding them have great medical, sociological, and economic importance.

Dementia praecox occupies a distinctive place among the various groups of mental disease. It is more perplexing and more baffling than any other form. As many persons afflicted with this disorder enter hospitals early in life and remain there until old age, there has been a continuous accumulation of dementia-praecox patients, with the result that they now constitute the largest single institutional problem in this country. They outnumber patients with all other forms of mental disease combined. They are twice as numerous as persons in hospitals for the treatment of tuberculosis. They exceed the total population of all institutions for the feebleminded and epileptics and state prisons.

* The author wishes to acknowledge the assistance of Dr. Horatio M. Pollock, Statistician of the New York State Hospital Commission, particularly in preparing the portion of this article relating to economic cost.

On January 1, 1920, there were 232,680 patients with mental diseases in institutions in this country.[1] No enumeration was made by psychoses that would show the number of persons with dementia praecox in this group. However, a census of the patients in the state hospitals in New York on June 30, 1920, showed that 59 per cent were cases of dementia praecox. The percentage for the country as a whole would be somewhat lower, as the patients in New York represent the accumulation of many years. Other things being equal, the older the institution, the higher is the ratio of dementia-praecox patients to the total number. A conservative estimate of dementia-praecox cases among patients in hospitals for mental diseases in this country at the present time would be 55 per cent. This means that there are approximately 130,000 persons with this form of mental disease in these institutions. On account of the absence of marked psychotic symptoms, a large number of persons with this form of mental disease never reach hospitals, but are in the community as loafers, beggars, and tramps, or swell the population of penal institutions and almshouses.

Of 21,012[2] patients with mental diseases admitted for the first time to 72 state hospitals during the year 1920, 5,676, or 27 per cent, were cases of dementia praecox. During that year there were approximately 50,000 new admissions with mental diseases to all hospitals devoted to their care. On this basis the number of new cases of dementia praecox reaching hospitals for mental diseases is more than 13,000 annually. In other words, in dementia praecox we have a form of mental disease that at the present time requires the institutional treatment of at least 130,000 persons, and each year causes the withdrawal from society into these institutions of over 13,000 new cases.

The question naturally arises: What of those persons with dementia praecox who are returned to the community from

[1] *Patients with Mental Disease, Mental Defect, Epilepsy, Alcoholism and Drug Addiction in Institutions in the United States, January 1, 1920.* By Horatio M. Pollock and Edith M. Furbush. MENTAL HYGIENE, Vol. 5, pp. 139-69, January, 1921.

[2] *Comparative Statistics of State Hospitals for Mental Diseases, 1920.* By Horatio M. Pollock and Edith M. Furbush. Published by the Bureau of Statistics, The National Committee for Mental Hygiene, 1922.

hospitals each year? During the year 1920, there were 3,668 cases of dementia praecox discharged into the community from 69 state hospitals, 10 per cent of whom were discharged as recovered, 67 per cent as improved, and 23 per cent as unimproved. These patients represented 27 per cent of the total number discharged from these institutions. The number of patients discharged from all hospitals for mental diseases has been estimated at 32,000 annually. The dementia-praecox patients among these discharges would, therefore, approximate 8,600. Large as this number may seem, it must be remembered that the great majority do not become independent, self-supporting citizens and that a considerable number later return to hospitals as readmissions. During the year 1920, there were 5,276 readmissions to 70 state hospitals. Of this number 1,722, or 33 per cent, were cases of dementia praecox. On this basis, among the 14,000 readmissions to state hospitals each year, there would be over 4,500 dementia-praecox patients.

Of the 5,676 new cases of dementia praecox admitted to 72 state hospitals in 1920, 3,144 were males and 2,532 were females. In other words, there were 124 males for each 100 females. The number of males per 100 females in the general population of this country on January 1, 1920, was 104.

With respect to age, it was found that of each 100 new admissions with dementia praecox, 8 entered the hospital before reaching the age of twenty years, 40 between twenty and thirty, and 32 between thirty and forty; the remaining 20 were forty years of age or over at the time of admission. That 52 per cent were thirty years or over at the time of admission may be explained by the fact that in many instances a long interval elapses between the onset of this disease and admission to a hospital. Marked differences appeared in the age distribution of the two sexes. Fifty-six per cent of the male cases and only 38 per cent of the female cases were under thirty years of age at the time of admission; 87 per cent of the males and 71 per cent of the females were under forty years of age. The percentages of males and females between the ages of thirty and forty were almost the same.

The degree of education of these admissions may be of in-

terest. Of each 100 cases whose degree of education was ascertained, 7 were illiterate, 25 were able to read and write only, 56 had a common-school education, 10 had attended high school, and 2 had attended college.

As regards environment, it was found that 73 per cent came from urban communities and only 25 per cent from rural districts, while the environment of 2 per cent was unascertained. The environment of the United States as a whole is 51 per cent urban and 49 per cent rural. The terms urban and rural are used as in the United States census classification, urban applying to places having a population of 2,500 or over, all other places being considered as rural.

A study[1] of first admissions to state hospitals during 1919 showed that the rates for dementia-praecox first admissions per 100,000 of general population of the same environment were as follows: urban 19.4 and rural 9.5. These figures differed considerably from the rates found for the other psychoses, as shown by the following summary:

Environment of First Admissions to State Hospitals

PSYCHOSES	RATES PER 100,000 OF POPULATION OF SAME ENVIRONMENT	
	Urban	Rural
Senile	7.2	5.4
With cerebral arteriosclerosis	3.3	1.4
General paralysis	8.6	2.0
Alcoholic	2.8	0.6
Manic-depressive	10.5	6.8
Dementia praecox	19.4	9.5
All psychoses	68.2	36.0

The excessively high rate of dementia praecox in cities may be due to some or all of the following factors: stress of city life on persons unfavorably situated, complicated city life making it more difficult even for milder cases to adjust to their environment, milder cases being brought to the attention more generally in urban than in rural communities, some-

[1] *Mental Diseases in Twelve States, 1919.* By Horatio M. Pollock and Edith M. Furbush. MENTAL HYGIENE, Vol. 5, pp. 353-89, April, 1921.

thing in the nature of the disease itself that makes it essentially prevalent in urban communities, or something in the nature of persons who develop the disease that makes them seek an urban environment.

In a study[1] of 9,024 dementia-praecox patients admitted to the New York state hospitals from October 1, 1911, to June 30, 1918, Dr. Horatio M. Pollock found that the rate of incidence of dementia praecox was much higher in urban than in rural districts, and that the rate was higher in large cities than in small ones, but that individual exceptions seemed to indicate that the size of the city was not a dominant factor.

With respect to the economic condition of dementia-praecox first admissions to state hospitals throughout the country during 1920, it was found that of each 100 cases, 18 were reported as "dependent", 63 as "marginal", and 19 as "comfortable". The corresponding figures for all other psychoses were 21, 54, and 25. These terms are thus defined: "dependent", lacking in necessities of life or receiving aid from public funds or persons outside the immediate family; "marginal", living on daily earnings, but accumulating little or nothing, being on the margin between self-support and dependency; and "comfortable", having accumulated resources sufficient to maintain self and family for at least four months.

Comparatively few patients with dementia praecox are intemperate users of alcohol. Of each 100 cases whose alcoholic habits were ascertained, 54 were abstinent, 35 temperate, and 11 intemperate. The corresponding numbers for all other forms of mental disease were 54, 30, and 16.

Of each 100 cases of dementia praecox whose marital condition at the time of admission was ascertained, 61 were single, 31 were married, 4 were widowed, 2 were separated, and 2 were divorced. The following summary gives the corresponding percentages by sexes:

1 *Geographical Distribution of Dementia Praecox in New York State.* By Horatio M. Pollock. *The State Hospital Quarterly*, Vol. 4, pp. 312-24, May, 1919.

Marital Condition of First Admissions with Dementia Praecox

MARITAL CONDITION	NUMBER		PER CENT	
	Males	Females	Males	Females
Single	2,401	1,100	75.0	43.2
Married	649	1,131	20.3	44.4
Widowed	67	196	2.1	7.7
Separated	36	59	1.1	2.3
Divorced	47	63	1.5	2.5
Total ascertained	3,200	2,549	100.0	100.0

The differences in percentages are noteworthy. Particularly striking is the large percentage of single men. This is accounted for in part by the fact that the onset of this form of mental disease occurs at an earlier age among males than among females, and in part by the fact that women as a rule marry younger than do men. There are doubtless other factors to account for this large percentage.

The foregoing social facts were obtained from uniform tabular forms received from state hospitals throughout the country. Other data such as occupation, temperamental make-up, nativity, and race are worthy of consideration. A detailed study[1] of the occupations of new admissions with dementia praecox to the New York state hospitals from October 1, 1909 to June 30, 1916, including a total of 7,026 persons, demonstrated that they came from all branches of industry, that the rate was higher in indoor than in outdoor occupations, and that there was a high rate in occupations requiring close application with accompanying eye strain. It was found that a disproportionate number of female patients came from domestic and personal service, that the average rate among employed women was higher than among employed men, but that in clerical service the rate was higher among men than among women.

In the report of the New York State Hospital Commission for the year that ended June 30, 1920, the 1,926 new admissions with dementia praecox were classified with reference to temperamental make-up. Of these patients 29 per cent were

1 *Occupation and Dementia Praecox.* By William J. Nolan. *The State Hospital Quarterly*, Vol. 3, pp. 127-154, February, 1918.

reported as temperamentally normal prior to the onset of the disease, 44 per cent as temperamentally abnormal, and 27 per cent as unascertained. The largest group of the cases reported as temperamentally abnormal were of a seclusive make-up. Other groups were classified as depressive, unstable, suspicious, egotistical, irritable, sexually abnormal, and criminalistic.

As regards the race of these same persons with dementia praecox admitted to the New York state hospitals, it was found that the Irish contributed the largest number of any one race—16 per cent—followed by the Hebrew race with 12 per cent, the German with 11 per cent, and the Slavonic and Italian races each with 10 per cent. The following summary shows the percentage of dementia-praecox cases among the first admissions of each race:

Race of First Admissions with Dementia Praecox, New York State Hospitals

RACE	TOTAL FIRST ADMISSIONS	DEMENTIA PRAECOX	
		Number	Per cent
African	255	85	33.3
English	340	51	15.0
German	770	216	28.1
Hebrew	693	229	33.0
Irish	1,086	304	28.0
Italian	563	185	32.9
Slavonic	407	190	46.7
Mixed	1,589	403	25.4
Other races	548	191	34.9
Unascertained	322	72	22.4
Total	6,573	1,926	29.3

In a study[1] of dementia-praecox first admissions to the New York state hospitals from October 1, 1911 to June 30, 1918, it was found that the rate per 100,000 of general population among the foreign born was higher than among the native born. The foreign born came principally from Austria, Germany, Hungary, Ireland, Italy, and Russia. The

[1] *Sex, Age, and Nativity of Dementia Praecox First Admissions to the New York State Hospitals, 1913 to 1918.* By Horatio M. Pollock and William J. Nolan. *The State Hospital Quarterly*, Vol. 4, pp. 498-516, August, 1919.

following summary presents the number and rate per 100,000 of general population of the same nativity for each of these countries as determined from this report:

Nativity of First Admissions with Dementia Praecox, New York State Hospitals

NATIVITY	NUMBER	RATE
Austria	598	244.1
Germany	488	111.7
Hungary	240	247.8
Ireland	528	143.5
Italy	528	111.8
Russia	886	158.5

Of the 2,414 dementia-praecox patients who died in 74 state hospitals throughout the country during 1920, 36, or 1 per cent, were under twenty years of age; 371, or 15 per cent, were from twenty to thirty; 564, or 23 per cent, were from thirty to forty; 432, or 18 per cent, from forty to fifty; 407, or 17 per cent, from fifty to sixty; 333, or 14 per cent, from sixty to seventy; and 262, or 11 per cent, were seventy years and over. In the case of 9 the age at death was not ascertained.

Of more significance than the age at death of these patients is their length of hospital residence. It was found that of each 100 deaths, 14 had a hospital residence of less than one year; 22, more than one, but less than five years; 19, from five to ten years; 19, from eleven to nineteen years; and 26 for twenty years or over. Similar percentages by sexes are shown in the following summary:

Hospital Residence of Patients with Dementia Praecox Dying in State Hospitals

HOSPITAL RESIDENCE	PER CENT	
	Males	Females
Under 1 year	12.4	16.5
1 to 4 years	24.0	20.5
5 to 10 years	19.6	17.7
11 to 19 years	17.9	19.8
20 years and over	26.1	25.5
Total	100.0	100.0

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Total	100.0	100.0

A comparison of the average length of hospital life in the principal psychoses of patients who died in the New York state hospitals during 1920[1] may be of interest:

Average Length of Hospital Life in Principal Psychoses, New York State Hospitals

PSYCHOSES	AVERAGE LENGTH OF HOSPITAL LIFE
Senile	2.0 years
With cerebral arteriosclerosis	0.9
General paralysis	1.2
Alcoholic	7.6
Manic-depressive	3.7
Involution melancholia	3.3
Dementia praecox	14.7
Paranoia or paranoid conditions	12.3
Epileptic psychoses	10.3

It will be seen from the above that dementia-praecox patients remain in hospitals longer than any of the other groups, four times as long as manic-depressive patients, twice as long as persons with alcoholic psychoses, and over twelve times as long as patients with general paralysis.

The causes of death of patients with dementia praecox who died in state hospitals throughout the country during 1920 were as follows: 1,065, or 44 per cent, from general diseases; 191, or 8 per cent, from diseases of the nervous system; 473, or 20 per cent, from diseases of the circulatory system; 303, or 13 per cent, from diseases of the respiratory system; 173, or 7 per cent, from diseases of the digestive system; 158, or 6 per cent, from diseases of the genito-urinary system; and 51, or 2 per cent, from other causes. The following summary gives the principal causes of death:

[1] Thirty-Second Annual Report of the State Hospital Commission, July 1, 1919 to June 30, 1920. Albany, 1921.

Causes of Death of Patients with Dementia Praecox Dying in State Hospitals

CAUSE OF DEATH	NUMBER	PER CENT
Tuberculosis of lungs	786	32.6
Other forms of tuberculosis	56	2.3
Cancer	65	2.7
Apoplexy	66	2.7
Myocarditis	171	7.1
Endocarditis	125	5.2
Arteriosclerosis	85	3.5
Bronchopneumonia	123	5.1
Lobar pneumonia	140	5.8
Diarrhea and enteritis	70	2.9
Nephritis	141	5.8
Other causes	586	24.3
Total	2,414	100.0

It may be of interest to know that 16 committed suicide and 2 deaths were due to homicide.

It has been estimated that about 30,000 persons die annually in hospitals for mental diseases. In the group of hospitals studied, persons dying with dementia praecox constituted 21 per cent of the total deaths during the year 1920. If this percentage holds good for the remaining hospitals, over 6,000 patients with dementia praecox die annually in hospitals for mental diseases in this country.

Turning from the social to the economic aspects of dementia praecox, the question arises: What is the economic loss to this country on account of dementia praecox? The economic loss on account of any mental disease consists of two principal factors—namely, the cost of maintenance of persons having the disease and the loss of earnings due to their incapacity. Other minor factors are involved, such as expenses incurred by relatives of patients and losses due to the sudden disruption of the patients' business relations. The latter items cannot be measured and there are no data from which satisfactory estimates may be made.

The average per capita cost of maintenance of patients in 72 state hospitals during the fiscal year that ended in 1920

was approximately $315.[1] This amount does not include interest or depreciation on hospital plants. Other studies have shown that the per capita investment in buildings and personal property necessary for the care of patients is approximately $1,000. Assuming this amount to be the average for the country as a whole and computing interest at 5 per cent and depreciation at 2 per cent, the annual investment charge per patient would be $70. This amount added to the maintenance cost would make the annual per capita cost of hospital care for patients $385. On this basis the total yearly per capita cost of the 130,000 dementia-praecox patients under treatment in hospitals at the present time would be $50,050,000.

Dementia praecox is a malady from which very few persons fully recover. It is true that many patients improve under hospital treatment and are discharged, but a large majority are not able to earn more than enough to support themselves while outside the institution, and many are partly dependent upon relatives. Some dementia-praecox patients do productive work within institutions, but as such work reduces the cost of maintenance, it is taken into account in part by the use of the net maintenance cost in these computations. Assuming that the average discharged dementia-praecox patient earns only his maintenance, the economic loss on account of earnings at the time of the first admission of a dementia-praecox patient would be the present worth of the probable future net earnings of a healthy person of the same age during the balance of the productive period of life. It is assumed that the period of productivity ends at the close of the sixty-fifth year and that the average earnings are the same throughout the years of productivity. The average per capita earnings of males above the cost of maintenance are estimated at $500 a year and those of females above cost of maintenance at $100.

The number of dementia-praecox patients annually admitted for the first time has been estimated at 13,000 (page 289), of whom 6,800 have been assumed to be males and 6,200 females. These figures conform closely with the ratios found in previous studies. These first admissions are classified ac-

[1] *Comparative Statistics of State Hospitals for Mental Diseases, 1920.* See note 2, page 289.

cording to age, and the loss of earnings at each age is taken to be the present worth on a 4 per cent basis of the total estimated future earnings during the period of productivity. The annual loss of earnings on account of the onset of dementia praecox among males, computed in this manner,[1] amounts to $62,900,000, and that due to the onset of dementia praecox among females to $10,700,000.

The annual economic loss to the nation on account of dementia praecox may therefore be summarized as follows:

Total annual cost of maintenance in institutions.	$ 50,050,000
Loss of earnings, males.....	62,900,000
Loss of earnings, females.....	10,700,000
Total.....	$123,650,000

The magnitude of the cost—both social and economic—of dementia praecox urgently calls for preventive action. What can be done to reduce the extent of this disorder and the resulting losses? The following lines of action are indicated: first, intensive research directed toward a more thorough understanding of the nature of the disease itself, and second, a more *active application of existing knowledge,* with a view to restoring to the community an increasing number of dementia-praecox patients and to identifying a larger number of potential cases in the community before marked psychotic symptoms have developed.

[1] For a more detailed account of the method of computation see *The Economic Loss to the State of New York on Account of Syphilitic Mental Diseases During the Fiscal Year Ending June 30, 1917.* By Horatio M. Pollock. *The State Hospital Quarterly,* Vol. 3, pp. 241-46, May, 1918.

MENTAL HEALTH AND THE NEWSPAPER*

NELSON ANTRIM CRAWFORD

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THE ideal of mental health and the ideal of the newspaper are properly the same. Truth is the ideal of both. Mental ill health is invariably associated with a variation from truth. It is not necessary that a person have delusions, hallucinations, or fixed ideas in order to depart from the truth. Truth involves every phase of life—physical, intellectual, and emotional, to use an old classification. The mental attitude of a person affected with a phobia or a psychoneurosis is by that fact so directed to one aspect of life—and not infrequently an aspect of life that is no longer of race service—that he fails to preserve a proper balance with reference to the other aspects of life, which invariably are more important. Every mental disease, however slight, involves in some measure a distortion of the truth. With our knowledge of the remarkable widening of the range of mental disease by psychological discoveries, we are probably safe in stating also the converse of this theory—that every distortion of the truth is traceable, directly or indirectly, to some form of mental distortion or pathology.

The ideal of the newspaper is, as its name indicates, to present the news—that is, to state objective facts accurately, fairly, and understandably. With the development of modern science, investigation, and industry, many apparently objective facts have no vital meaning for the average reader without expert interpretation. If the newspaper is to be what it should be, in accordance with its ideal as an organ of the truth, it must, where necessary, resort to expert interpretation, being careful that such interpretation is just and unbiased. The newspaper resorts regularly to interpretation—not always expert, however—of political and economic problems. It resorts to expert interpretation of scientific matters related to industry. Unfortunately, it almost never employs

* Read before the Annual Meeting of the Kansas Society for Mental Hygiene, Topeka, December 8, 1921.

expert interpretation of psychological and psychiatric problems. By resorting to expert interpretation of these problems, it could educate the public to an understanding of many abnormalities that are a constant menace, but concerning which the average reader has no dependable knowledge.

Particularly in the field of criminology is this important. Our methods of dealing with crime, though less barbarous and more kindly, are little more sensible, so far as the habitual criminal are concerned, than the methods of many years ago. There is a prevalent belief that habitual crime is due to intellectual ignorance. As a matter of fact, it is due to nothing of the sort. Habitual crime is in large part, if not entirely, the result of organic or functional mental disease. Education of the intellect is no cure for this. This becomes at once obvious when one considers the fact that the world's leaders in statesmanship, in art, in invention, and in other fields have not infrequently been psychopathic, though not for the most part in a criminal direction. The same theory holds good with respect to the criminally psychopathic. The cure must be prescribed by the psychiatrist rather than by the educator.

The psychological disorders that are promotive of crime will not be cured until the public gains an understanding of these disorders, and the newspaper is the only medium through which the general public will be able to gain such an understanding, for the newspaper is all that it reads. The popular reaction to discussion of the relation of crime to mental disease is that too many persons are acquitted of murder, for instance, on the ground of insanity. The public is palpably wrong. Not fewer, but more, murderers are insane than have been declared insane by the courts. If, however, there were an intelligent grasp of the facts of mental disease, the condition of these persons would have been recognized and they would have been cured or restrained before they had had opportunity to commit murder. In this campaign of education the newspaper can be of marked service.

Probably the most dangerous situation, so far as criminology is concerned, is the public ignorance concerning sex and sex crimes. When sex crimes occur, the average newspaper and the average reader shout such terms as "fiend" and "degeneracy". They feel the common repugnance to the unnatural or the abnormal, and see in persons guilty of sex

crimes a wilful moral guilt. As a matter of fact, sex crimes are almost invariably, if not absolutely invariably, the result of definitely recognized psychopathies, and psychopathies are cured neither by imprisonment nor by any other punishment. The mob that lynches a prisoner for a sex crime merely bears witness to a sexual aberration of its own. There is a strong sadistic component in the mental life of the race, and the members of the lynching mob are simply giving vent to this psychopathological condition in themselves.

To the improvement of conditions in these respects the newspapers and magazines are doing little or nothing. It is an astounding fact that in the various trials in which Harry K. Thaw was involved and concerning which certain newspapers published such revolting details that they were threatened with criminal prosecution, no newspaper or magazine, to the best of my knowledge, published a sound, understandable explanation of the sexual psychopathy with which Thaw was and is afflicted, or discussed the means of guarding against the menace of this condition in human life.

Again, in all the stories that appeared in the Kansas City papers last summer concerning a "vice ring" in that city, there was line after line of suggestive material that might easily cause a boy or girl to wish to delve further into the type of vice represented, but there was not a line in any newspaper in that city that gave a rational explanation of the sexual inversion with which the leaders of this ring were afflicted, or the proper psychiatric method of handling such cases. The leaders of this vice ring are presumably complete inverts. Whether one holds that this character is inherited, or maintains with the Freudian school that it is acquired in infancy or early childhood, the fact remains that the individual so afflicted is frequently incapable of self-restraint and the mental disease itself is of doubtful curability at the present time. The danger to society from persons of this type is that they may engage in abnormal practices with persons who are at least partly normal and may develop in them serious neuroses. It is dangerous to the other inmates of a prison that men of this type be confined with them. The method that most psychiatrists would suggest would probably be confinement in a psychopathic hospital, where studies might be made to discover, if possible, a cure for the abnor-

mality. So long as sex crimes are placed on the basis of wilful moral turpitude, they are bound to occur again and again; the vice ring of Kansas City will be repeated in other cities, perhaps in Kansas City itself. When the people once understand such psychopathies, however, they will take sensible steps, through greater care in breeding, to prevent psychopathic inheritance; they will be solicitous as to the early life of children; and when psychopathic conditions do develop, they will handle them from the point of view of science and not that of the ignorant rabble.

In this the newspapers can, if they will, be of enormous practical service. They are the popular educators of the day. No false modesty or fear of shocking popular prejudices should prevent the newspapers, when crimes that justify it are committed, from interpreting, scientifically and intelligently, what has actually taken place and what can be done to prevent its recurrence.

Not only in such extreme cases, but in the matter of the more common disorders, may the newspapers be of service. A physician in Kansas City has told me that public sentiment is so uninformed that it would be impossible in that town to enforce the state law regarding the segregation of the feeble-minded. The public does not understand the importance of this measure and the newspapers should inform it.

The other relationship of the newspapers to mental health that I wish to discuss is a much more complex one. It involves the basis of many psychopathies, not only individual, but national and racial. That basis is fear. Fear is still one of the most potent forces in human conduct.

Fear is a characteristic of the newspapers and of the American people at the same time. It is not physical fear, for Americans have shown courage and endurance times without number. It is rather intellectual and spiritual fear, based on nothing that affords a reasonable basis for fear. It is, in short, psychopathological fear, as clearly such as fear of an open space or fear of a cat. Most conspicuously it takes the form of fear of and deference to the herd, the whole body of people. Necessary for the preservation of the race at some distant period, this phobia is preserved as a psychopathological anomaly in the United States of America to-day.

Pathological fear always masks or rationalizes itself in other guises. No individual is willing to admit, even to himself, that he is a coward. The fear "complex" is inhibited by the psychic "censor" and manifests itself in indirect and devious ways. Conduct actually inspired by fear is explained on the basis of various false rationalizations.

The newspaper, as at present constituted, is essentially a herd institution. And the herd in the United States is a very closely massed formation, held together by a great body of beliefs and taboos. One of its most marked characteristics is its fear of and hostility to new ideas. The American public does not want facts; it wants only pleasant facts.

The newspapers, generally speaking, defer to the American public's fear of ideas. The herd fears ideas; the newspaper fears the herd; therefore, the newspaper fears ideas. Thus is established a vicious circle of psychopathological fear.

The newspaper's fear seems in some cases justified. When a paper does publish facts that tend to conflict with herd dogmas, the herd often manifests its resentment by canceling subscriptions, stopping advertising, or at the least writing letters expressing regret that the newspaper should tell a truth of which the herd disapproves. Amusing—isn't it?—and at the same time tragic that people can think of truth as something that may be approved or disapproved!

At the same time, many a newspaper consciously encourages the herd's fear of ideas by suppressing, distorting, or coloring the facts in such a way as to give a wholly different impression from that which the facts, objectively and honestly stated, would give. I have heard newspaper men seriously question whether the public ought to be given this or that fact. As if in a democracy the people were supposed to govern in ignorance of the facts or in possession of facts distorted by interested persons!

Until pathological fear is eliminated from American life, we shall have neither mentally healthy individuals nor a mentally healthy nation. To eliminate this type of fear, the coöperation of the newspapers is essential. The chains binding the newspaper to the herd, the chains binding the herd to a fixed deposit of tradition and taboo, must be broken. Through the influence of journals of opinion, of open forums, of educational institutions, of liberal movements of all sorts,

more and more men and women are breaking away from the herd dogmas. They furnish a nucleus to which newspapers willing to stand for the truth regardless of popular opinion may appeal. If a sufficient number of leading newspapers will break away from their fear of the herd, they can accomplish more than any other institution to destroy the attitude of fear that tends to paralyze American thought and life.

To sum up, the newspaper has the same ideal as the seeker for mental health. That ideal is truth. The newspaper can aid in the establishment of higher standards of mental health in the nation, first, by interpreting to the people the mental diseases that predispose to crime or other antisocial activity; secondly, by aiding, both through precept and example, in the elimination of those pathological fears that are so marked and sinister a characteristic of American life.

A SOCIAL-SERVICE DEPARTMENT IN A STATE HOSPITAL

MARIE L. DONOHOE

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SOCIAL service has been established in the state hospitals of Massachusetts for a sufficient period of time to prove its value both to the hospitals and to the community. There would seem to be no longer a question that a social-service department, properly equipped, is essential if a hospital is to fulfill its obligations adequately and is to dispense economically the private or public funds at its disposal. The experience in Massachusetts has been sufficiently long, furthermore, to warrant some conclusions as to the type of organization that should be planned for a social-service department in a state hospital. At least this is clear—for adequate work there must be an adequate staff. In Massachusetts patients are discharged from the state hospital on trial visits of one year, and during this year the social-service department of the hospital is held responsible for the patient. But if this supervisory care in the community is to be adequate, it is obvious that there must be a sufficient corps of workers. If a problem arises in the community in relation to a patient, it is the social-service department that receives the criticism if the problem is not handled efficiently. But such problems are too numerous to be handled by one or two workers. Dr. Henry P. Frost, the late superintendent of the Boston State Hospital, said in his report of 1915: "The service is most valuable, but its possibilities are merely indicated, not realized by the single worker so far available." But there is a larger question involved than the criticism of a department. A patient on visit is still legally under the care of the hospital—although the hospital cannot care for the patient. One may ask, therefore, what moral right has a hospital to claim legal rights over its patients in the community if it cannot give these patients supervision and care when they are needed.

After an association of six years with two state hospitals

in Massachusetts, I present the following plan as a good working department in any large state hospital:

SOCIAL-SERVICE DEPARTMENT IN A STATE HOSPITAL

I. *Chief of Social Service.*
   a. To organize.
      Plan the character of the work.
      Limit the extent of the work.
      Know the assistance needed in the department.
      Know the ways of obtaining this assistance.
   b. To represent social service in the out-patient department.
   c. To do educational work.
      Lectures outside the hospital, to organizations, clubs, students.
      Lectures to the nurses of the hospital.
   d. To train student and volunteer workers.

II. *Historian*
   a. To take medical histories during absence of the physicians.
   b. To take social histories on every case.
   c. To sort all admissions, referring to the chief all cases that need social-service care.
   d. To do some of the investigation for diagnosis.

III. *Social Case-workers.*
   a. Ward social worker at the hospital.
   b. Boarding-out visitor. (Each hospital should have absolute charge of its boarding cases.)
      To visit the patients when boarded.
      To enlarge this department, finding opportunities to make it grow.
      To do some medical follow-up work.
   c. Case-workers (two at least).
      To do the investigating for diagnosis.
      At least two workers to arrange for the care of the patients in their own homes and to give intensive care of the patients during trial visit.
      To carry the family through the difficulties of the patient's hospital residence.
      To plan for the patient's return when necessary.
   4. Employment worker.
      To investigate opportunities for the employment of patients on visit.
      To supervise patients when employment is found.
   e. Syphilis worker.
      To work with the families of all patients who are admitted showing symptoms of syphilis.
      To follow up all patients who leave the hospital and attempt to see that treatment is received in cases recommended by the medical staff.
   f. Case-worker in the out-patient department.
      To do the case-work of those patients who come to the clinic and need social care.

IV. *Clerical Assistants.*
   a. Office manager and secretary to chief.
   b. Stenographer.
      Filing, record writing, etc.

I. *The Chief.*

The chief should be directly responsible to the superintendent for the policies of her department. She should be responsible for the entire organization of the department. She should plan and distribute the work and limit its extent. She should have the privilege of refusing to accept cases that do not rightly belong to the social service. She should know what assistance is needed for conducting the department properly and should be acquainted with ways of obtaining assistance when it is needed. The chief of the service should have control of all social work done in the out-patient department. The actual case-work she should delegate to the case-worker in the out-patient department, but all cases accepted for social care should be approved by the physician in charge of the out-patient department and the chief of social service. Educational work in the community comes under the duties of the chief. Lecturing before physicians, nurses, clubs, and students of social work should be considered a part of her work. The training of students and volunteer workers should also be one of her duties. All research work done in the department should be under the direct supervision of the chief.

II. *Historian.*

In my opinion, the historian rightly belongs under the chief of the social service. She should be as well trained in taking good medical histories as she has been trained in taking good social histories. Every patient should, on admission, have a careful social history taken as well as a careful medical history. Every mental patient is potentially a social-service case. In a study made recently by a student worker at the Boston State Hospital, it was found that the majority of cases that came to the department for slight service were later taken on for intensive social care. At the present time, we realize that admission or commitment to a state hospital has been sought by the family or friends almost as a last resort. We are still dealing with an unenlightened public as far as mental illness is concerned. The educational work that can be done with the families of patients at the time of admission to the hospital is unlimited. Careful, direct information about the hospital—its functions, its rules, its aims, its treat-

ment—given to the family, brings to them comfort and relief and, in return, the hospital gets the benefit of intelligent interest, coöperation, and appreciation. An hour well spent at the time of admission saves the doctor many hours of explanation and the family of the patients many moments of worry and unhappiness. The historian should refer to the chief all cases that need social-service care.

III. *Social Case-workers.*

a. Ward social worker. There is, I feel, a definite need in every state hospital for the services of a social worker with the patients on the wards. Some link to connect the patient with his family and the outside world is necessary as part of the treatment. We all know that there are numberless patients in our state hospitals whose greatest need is some form of reëducation. Some of this work of reëducation is, of course, done by the psychiatrist. The doctor, however, has not the time, the patience, or the training to do all this work, nor is he likely to have an adequate knowledge of the situation outside the hospital. A specially trained worker who understands the patient's case, who is well versed in the community's resources, and in the particular problems of the patients, can do this work even more efficiently than the doctor. All this work done in the hospital, however, must be done under the close direction of the physician in charge of the patient.

b. Boarding-out worker. The family-care or boarding-out department of a state hospital offers large opportunities to a certain type of acute patient and to certain chronic patients. When there are no relatives, no friends to offer homes to improved patients and patients who need community life in restoring them to normal living, good boarding homes are needed. A good boarding home also offers to a certain type of chronic mental patient normal home life outside institutional walls. For the past few years, because of the high cost of living, it has been almost impossible to enlarge the family-care departments of our state hospitals. The fact is that the sum allowed by the Department of Mental Diseases is not large enough to provide proper care and living conditions. The boarding-out department cannot grow until an adequate sum is allowed for the care of patients in the community.

The boarding-out visitor should study the patients recommended by the physician for the department, should investigate and visit the homes, and study the boarding mistresses so that she can place intelligently the patients in the homes where they will fit most contentedly. Numbers of patients who originally start community life again in the boarding-out department can later be discharged as self-supporting, happily adjusted individuals.

c. After-care workers. There should be at least two workers in a large state hospital to do real social case-work. Thorough investigations of the situations that led to commitment, careful planning with the families of patients, assisting the family through the crisis of commitment, tying them up with the proper agencies if they are in need of financial aid or medical attention, assisting with the care of children, educating all the members of the family, helping the neighbors, the relatives, and the friends to understand the illness, preparing the way for a speedy return to the community in every possible case, careful, intelligent supervision of the patient over a long period after he has returned to his home, are all necessary if we expect success in reëstablishing and readjusting our patients. What right have we to expect that the patient will continue well if we allow him to return to the same conditions that led to his break down, such as illness in other members of the family, deep financial worries, unsanitary home conditions, unfriendliness and misunderstanding?

d. Employment worker. During normal times, it is difficult to find employment for the handicapped. The physically handicapped stands a much better chance than the mentally handicapped, for his illness is at least partially understood. The world at large still fears the mentally ill, still does not understand and is skeptical about offering employment. A worker whose entire time could be given to studying the field of employment, studying the positions in her community that could be safely offered to mental patients, who could find employment and then carefully supervise for several months those who are employed, would undoubtedly prove an economic factor in the state. Besides the economic value to the state and to the community, the therapeutic value to the patients of such work cannot be emphasized too strongly.

e. Syphilis worker. Unquestionably there should be in every state hospital a social worker to handle the syphilis problem. All patients who are committed to state hospitals are examined for syphilis as a matter of routine, and in all cases possible, where the Wassermann test is found positive, examinations of the spinal fluid are made. I think I am correct in my statement that in no state hospital except the Psychopathic has any definite program been offered in the way of preventive work with the families of patients whose laboratory findings are positive. The Boston Psychopathic Hospital is the only hospital in the state that makes any attempt to deal with this serious problem.[1] The field has unlimited possibilities for preventive work.

f. Case-worker in the out-patient department. The need of social service in any out-patient clinic hardly needs mentioning. Here, again, is a field for preventive medicine. The psychiatrist's recommendations, his plans for care and treatment, can be carried out only with the assistance of a specially trained psychiatric social worker. The out-patient departments of all our state hospitals should be enlarged, should go forth into the community as have the out-patient departments in all general hospitals.

IV. *Clerical Assistance.*

The filing, record keeping, and routine office work in a fully equipped social-service department are no small part of the day's work. This part of the work must be done and must be kept up to date to be of real value to the physicians. An office manager to do the secretarial work of the chief, and at least one stenographer to do the record writing, filing, etc., are absolutely essential. With proper stenographic help, more attention could be given to the records. Good work can be demonstrated only by good records.

1 For literature on this subject see *The Family of the Neurosyphilitic*, by Harry C. Solomon and Maida H. Solomon. MENTAL HYGIENE, Vol. 2, pp. 71-80, January, 1918; *A Study of the Economic Status of Forty-one Paretic Patients and Their Families*, by Harry C. Solomon and Maida H. Solomon, MENTAL HYGIENE, Vol. 5, pp. 556-65, July, 1921; *Effects of Syphilis on the Families of Syphilitics Seen in the Late Stages*, by Harry C. Solomon and Maida H. Solomon, *Social Hygiene*, Vol. 6, pp. 469-87, October, 1920; *Social Work and Neurosyphilis*, by Maida H. Solomon, *Social Hygiene*, Vol. 6, pp. 93-104, January, 1920.

PSYCHIATRIC SOCIAL WORK IN A RED CROSS CHAPTER*

MARGARET WORCH

IN August of 1919, Dr. Douglas A. Thom, of The National Committee for Mental Hygiene, went to St. Paul, Minnesota, to look over the field in order to see what were the opportunities for psychiatric social work in the care of ex-service men. There had never been any psychiatric social work done in St. Paul, so that a worker coming there would have a great deal of pioneering to do. Dr. Thom decided, in conference with the executive secretary of the Red Cross Chapter and with the executive secretary of the United Charities, that there was an opening for such a worker. In order to cover as large a field as possible, it was decided that the worker should divide her time between the United Charities, caring for civilian cases, and the Red Cross, caring for ex-service men. Her first obligation, however, was to the ex-service men.

Accordingly, a worker, whose expenses were paid by The National Committee for Mental Hygiene under the Anderson Fund, was sent to St. Paul in January of 1920. She worked during half of the week in the free medical dispensary of the United Charities, acting as clinic manager in a new nervous and mental clinic and doing social case-work and follow-up work on selected cases among the patients coming to the clinic. The other half of the week she gave to the Red Cross. For the first three months, she gave three mornings a week to home investigations of mental and nervous cases among the returned service men, and two hours one afternoon a week to office interviews in the Red Cross office. The cases were referred to her by the other workers in the chapter, who sent her such cases as seemed to them to present psychiatric problems, and by the neuropsychiatrists in the Public Health Service, who were glad to have social investigations made on their more puzzling cases.

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In St. Paul, as in all large cities, the aim of the Home Service is to assist ex-service men, soldiers, sailors, and marines, and their families, in their problems of social maladjustment. In rural communities, the Home Service does not limit itself to ex-service men, but in cities and communities where there are social organizations already operating the work is confined strictly to men who have been in military service and have a disability resulting therefrom for which they are entitled to compensation from the government. Compensation includes a monthly cash pension, ranging from eight to a hundred and fifty-seven dollars, and free medical treatment, either in clinic or in hospital. Every man honorably discharged from the service with a disability traceable to service, or aggravated by service, is entitled to this medical care, which is given through the United States Public Health Service.[1]

When the care of these men receiving treatment from the Public Health Service became an acute problem, it was found that the Public Health Service was not in a position to offer them social as well as medical treatment. The Red Cross, therefore, offered to look after the social treatment of these cases through the Home Service Section. Thus all social work for ex-service men devolves upon the Home Service in each locality. The Home Service tries to reach not only the individuals who need financial aid, but also those who are not socially adapted to their community. "The job of the Home Service worker concerns itself frequently with personal social service to many who under no circumstances can be classed as having problems due to poverty, so the time may come when rich as well as poor will seek the services of the social interpreter, to assist in solving their family problems."[2]

Cases are referred to the Home Service Section of the local chapters differently in different cities. In St. Paul, the Home

[1] This work is now being done by the Veterans' Bureau, which was created by Act of Congress, August 9, 1921, to take over the functions of the Bureau of War Risk Insurance and the Rehabilitation Division of the Board of Vocational Education, and all the activities of the Public Health Service relating to ex-service men, with the exception of the conduct of such hospitals and dispensaries as are operated by that service.

[2] Agnes L. Murray. *Case Work Above the Poverty Line.* Proceedings of the National Conference of Social Work, Kansas City, May, 1918.

Service receives a day sheet recording the names and addresses of all men who are examined at the Public Health Service clinic, and the name of the examining physician. If the man is not already known, a new case is at once opened, a complete medical report on the man's condition obtained from the Public Health Service, and a home investigation made within the month. All cases coming to our attention in this way were not immediately registered at the confidential exchange, since we felt that such registration would mean turning the exchange into a recording bureau for the men who received medical treatment from the Public Health Service. However, after the home investigation, the case was usually cleared through the exchange. If there was no registration already, and the case worker felt that there was no problem demanding attention, we made no registration. This arrangement applied to the psychiatric as well as to the general medical cases.

In October, 1920, the psychiatric social work in the chapter had so increased in volume that the Anderson Fund worker was allotted an untrained assistant, whose salary, however, was paid by the Red Cross Northern Division, not by the chapter. In November, the Anderson Fund worker found that it was necessary to give up her work in the United Charities Free Dispensary in order to devote her full time to the ex-service men. In January, 1921, about a year after psychiatric social work was first introduced into St. Paul, she resigned, and the chapter itself paid the salary of a full-time worker, giving her one of their regularly employed visitors as half-time assistant. These two workers handled on an average of one hundred cases a month.

A separate card index was kept for the nervous and mental patients. Each card contained a brief statement of all steps taken on the case, so that should it come up during the absence of the worker, any one in the office might tell what had been the last action taken. These cards were kept up to date, even if the record itself might be behind.[1]

[1] These cards were very helpful at first when the psychiatric social worker gave only half time to the Red Cross work. At present it is a question whether keeping them up does not take too much time, since there is usually a worker familiar with the case available in the office.

In addition to this index, all mental and nervous cases were "flagged" with green markers in the general file, so that no worker, in looking up a case unknown to her, would attempt to prescribe social treatment for a psychiatric patient without first consulting with the psychiatric social worker.

We made no distinction between long- and short-service cases. We tried to do what had to be done and a little bit more, but beyond this we could not go, because of pressure of work. Once a case was referred to the psychiatric social worker, she handled it in its entirety. She administered relief when it was necessary, and no relief was given to a psychiatric patient without her consent. If for any reason she thought such relief should be discontinued, her recommendation was practically always followed. She handled such matters as the drawing up of budgets when families were taken on for a long time, discussed ways of cutting down expenses, and so on. In addition, she gave the psychiatric patients informational service on government insurance, state bonus claims, and the like. I wish to stress this point particularly, as it is a departure from the practice in some offices, where the relief and financial sides of a case are handled by the family case-workers, and the technical sides of the government claims by a general informational worker. The practical arrangement whereby this was worked out meant that the psychiatric social worker gave the mornings to field work and the afternoons to office interviews. Our worker made no selection of the cases on which she wished to work. A few each month demanded concentrated treatment for a short time because of the nature of the problem involved. When a man had to be committed, it would sometimes take three or four days of work to arrange for the commitment, but once this was accomplished, the case became inactive for the time. When the doctor pronounced the man recovered, or when he died or left town permanently, we closed the case, but otherwise, once referred to the psychiatric social worker, it remained her problem and hers exclusively.

In order that we might see that no cases lapsed, we started a tickler file, setting the cases two months ahead from the date when last seen. This system had to be partially abandoned, however, because of pressure of work.

One of our initial difficulties was in obtaining diagnoses upon our cases. Very often a man would be referred by another worker in the chapter, who thought that he was "queer" or "nervous", and had found that he had had a psychiatric examination. In order to obtain the diagnosis, under the arrangements existing when the work first began, it was necessary to write to the liaison officer in the district supervisor's office, asking for the results of any psychiatric examinations that might have been made of this man. It took two weeks to receive an answer to this inquiry. Later, the psychiatric worker was given access to the files of the neuropsychiatrists, so that she could refer directly to them, without having to wait for a report of the diagnosis. This was of inestimable value in the social treatment of the cases. In February, 1921, a special arrangement was made with the chief of staff of the St. Paul clinic, whereby the psychiatric social worker received a carbon copy of all examinations and recommendations made upon the nervous and mental patients coming to the St. Paul clinic for treatment. The possession of these medical records expedited the work and automatically referred all cases not already known to the psychiatric social worker for her attention and for an investigation.

This was a great concession, and it was secured through the neuropsychiatrists in the Public Health Service. From the first, our relations with them were very encouraging and unusually close. We had free access to the records of the Public Health Service Mental and Nervous Clinic, as I have said, and free opportunity for conference with the psychiatrists in charge of the clinic. A course of treatment was usually mapped out by the psychiatrists in conference with the social worker, and difficult points were discussed before a decision was made. Usually these conferences occurred about once every ten days, but the psychiatrists were always available when an emergency arose. They made some sort of recommendation on practically all the patients coming to the clinic, for the worker to follow in her treatment. This coöperation was particularly helpful to the worker. No important steps were taken in the treatment of the mental and nervous patients among the ex-service men until the psychiatrists had first been consulted concerning their advisability.

When a patient was pronounced not compensable—that is, when it was decided by the Bureau of War Risk Insurance in Washington that the disability claimed was not a result of service[1]—we were obliged to turn the case over to a civilian organization, unless the man was anxious and able to reopen his case with affidavits, establishing the service connection of his disability. In turning over these cases to a civilian organization, we gave the essential facts, but not the diagnoses, since it is forbidden to give out diagnoses on any government patient. We described the condition of the patient in as simple language as possible, with no technical terms, at the end venturing a recommendation as to the best social treatment to pursue. The civilian organizations coöperated with us, and we were able to follow several of our patients through their reports, at least to a partial readjustment in the community. St. Paul has one mental and nervous clinic for the use of civilians; the physicians in charge of this clinic are the same as those in charge of the Public Health Service clinic. Thus the patient, when transferred to the civilian organization, is given the benefit of the same treatment as had been planned for him under the Public Health Service.

It is usually easy to hospitalize a man under the Public Health Service, but it is hard to have a man committed, since the Public Health Service does not commit any patient. All treatment received from the government is purely voluntary. Therefore, when a patient requires immediate hospital treatment and is unwilling to go to the hospital, or when the only Public Health Service hospital for the district is full, it is necessary for the patient to be committed through the local probate court and sent to a state hospital for the care of mental patients, where his expenses are paid by the government. From the state hospital he is often transferred to a Public Health Service hospital. Once in one of the Public Health Service hospitals for the care of mental patients, a man may

[1] The decision was based on the reports forwarded to the bureau by the local examining boards of the Public Health Service. Local examiners had not the power of deciding whether a case was or was not compensable. This has been changed by the passage of the Sweet Bill.

be restrained from leaving,[1] but there is no way of seeing that a man who is mentally ill and who refuses to go to a hospital will receive adequate care, unless he is committed directly to a civilian institution.

To facilitate these commitments, careful histories were taken on all cases, before the patient reached the psychiatrist. Although most of the nervous patients reached the psychiatrist before coming to the attention of the social worker, I believe that no psychotic patient reached the clinic without first coming to the attention of the social worker. The reason for this is obvious. Most of these men, if they were applying for treatment voluntarily, came into the Red Cross office in such an excited state that it was impossible not to detect their difficulty at once. In several cases, they were brought in by their relatives who demanded a "complete examination for insanity". The rest were referred to the psychiatric social worker by the Public Health Service itself, before they were referred to the psychiatrist.

When a man had to be committed to a civilian institution, we applied to the clerk of the probate court, to call in the Public Health Service psychiatrists as examining physicians. These psychiatrists had already examined the patient and had found him in need of commitment. The petition that the man be examined to determine his sanity was usually filed in the probate court by the relatives of the man. In a few cases, a private physician to whom the case was known filed the plea for a hearing.

Arrangements were made with the superintendent of the hospital to which the patients from St. Paul were sent, so that the social worker could keep in close touch with the men while in the hospital. Reports on the progress of the patients in the hospital were sent fairly often to the social worker, and she kept the hospital authorities in touch with the home situations, when these presented some special difficulty. She also sent full histories on all cases to the superintendent. When

[1] Legally this is not permissible, since the man is not committed to the hospital. Practically, many institutions hold mental patients on the grounds that they applied for treatment when sane, for a period of insanity through which they felt they might be going. Therefore, the hospital should hold them until they can apply for discharge as sane individuals.

the men were paroled, the Red Cross was notified, and through an agreement with the state board of control, the proper after care and supervision were given by the Red Cross social worker, without conflicting with the state parole agents, to whom the patient was technically paroled. Thus the patient was followed by the Red Cross psychiatric social worker, from the time of his first examination by the Public Health Service psychiatrist, through his commitment, while in the hospital, and again on his return to the community.

The paroled patients were kept in close touch with the physician. If any mental disturbance occurred, the state board of control was at once notified, and the patient returned to the hospital. When it was necessary, we gave the family of a patient in a hospital a weekly allowance to support them until the man's compensation came through. We found that when a patient was relieved from the worry and strain of supporting his family, he often improved rapidly in the hospital. No man was ever hindered from accepting hospital treatment recommended by the psychiatrist because he did not have enough money to support his family while he was in the hospital.

The Public Health Service asked for full psychiatric histories on all the psychotic patients, as a routine matter, and even suggested that we obtain full psychiatric histories on all cases referred to the psychiatrist. The plan was for us to see each man before the psychiatrist made his examination, and get from him his own account of his difficulties. This plan did not work out at all well. We found that many men concealed the true facts of the case, and many—in fact, the majority—of the nervous cases reached the physician before they reached the social worker, owing to some confusion in sorting out the nervous patients. Also, we could not afford the time necessary to take a long personal history on every patient. This would have meant that one worker did little else except take histories, when the number of new patients ran as high as twenty-five or thirty a month. A compromise was, therefore, arranged. We made full investigations on all mental patients, including interviews with relatives, explaining to them the necessity for hospital treatment, etc. On the nervous patients, we made a full home investigation and

talked with at least one disinterested informant. We attempted to find the origin of the trouble or the character trends of which it was the outcome. In addition, we tried to obtain a short personal history from the patient himself, to check with the information received from the outside source. This was done within a month from the time the case was first referred to us from the Public Health Service, through the carbon copy of the physician's report of his examination of the patient. In a great many cases, the investigation went no further than the home investigation and the interview with the patient himself; not because we felt that this was necessarily a sufficient investigation, but because, unless there were marked signs of social maladjustment, we had no time for further investigation. However, we did no intensive work without first having as full a social investigation to work upon as it was possible to obtain. In addition to this social information, we always had a full medical report on every case referred to us, which was obtained through the liaison staff at district headquarters, so that if a man needed care beyond that indicated by the diagnosis sheet received from the Mental and Nervous Clinic, we would be able to see that he got it, either by advising him to go to the Public Health Service to receive the treatment that had been recommended, or by conferring with the psychiatrist concerning this other physical condition and the best treatment for it in view of his mental or nervous condition.

The connection of the psychiatric social worker with the Federal Board for Vocational Education was never very satisfactory. Vocational training for the mentally disabled had never been tried to any great extent before the fall of 1920. The technique for handling these patients in conjunction with the chapter was never fully worked out. We tried sending histories to the board on these patients as a routine matter, but this was discontinued, as we felt that the educational value of the histories did not compensate for the real injury done to the men in labeling them "mental cases". That a history might be taken on a patient where the difficulty was slight or the disease mild was an idea very hard to get across. If a man's condition was bad enough to need three pages to explain it, it must be very bad indeed.

Our final solution was a compromise. We rigidly followed up the physician's recommendations on all the mental and nervous patients, either ourselves or through the board. This was easy to do, as we had the original diagnoses and recommendations on file in our own office. We held occasional conferences with the Federal Board executive, and gave a brief and informal history on each case as it was brought up for discussion, and with the executive tried to map out some form of treatment that would be helpful and constructive.

Owing to scarcity of employment, no effort was made this winter (1920-21) to try to establish relations with any of the large manufacturing concerns that might have been in a position to employ a man with a mental or nervous handicap. Temporary employment, which sometimes led to permanent work, was always obtainable through the employment bureau of the American Legion. We often referred men to this bureau, asking, for instance, that they be given work that would not require their climbing or bring them near machinery, in the case of epileptics, or that a man be given work out-of-doors, or on a farm, etc. The problem of employment for these patients while they are waiting for an award of vocational training is very great. There is no satisfactory way of meeting it at present, but signs point to the establishment of a bureau for the employment of the handicapped within a short time. Should the employment situation lighten, an attempt will be made to establish friendly relations with one of the big packing houses, either Swift's or Armour's, to secure employment through them. These houses offer a large variety of employment, and we have felt for some time that it would be possible to place patients with them, if the situation were carefully canvassed with the executives and the individual cases gone over with the foreman.

The St. Paul clinic takes care of a large number of men from the district (Montana, North and South Dakota, and Minnesota), as well as the men from St. Paul. A large number of these men became known to the St. Paul Red Cross while they were in St. Paul for treatment. There were also a great many men from the district who were receiving training from the Federal Board. When men of either of these

two classes returned to their homes, their names and addresses, together with a detailed report on their mental, physical, and social condition so far as known, were as a matter of routine referred to the neuropsychiatric liaison officer, who supervised, through correspondence, the after care of the nervous and mental patients when they had returned to their homes in the rural communities. In special cases, some of these men were kept under the supervision of the psychiatric social worker in the St. Paul office. If we had had any contact with the families of these men, or if we had had much contact with their local Home Service representative, we continued to supervise their care. This was done by letter, and in one or two cases, where the Home Service representative was coöperative, the results were good. We referred the case, with a complete history and recommendations, to the worker, outlining the treatment that seemed advisable and asking her to report back to us on the progress of the case. Most of the local representatives are untrained in the care and treatment of nervous and mental patients, but as a rule they are anxious to help, though frightened at the prospect of having to look out for a patient who is "queer". As the reports came back to our office, we suggested further steps in the treatment which we thought would be helpful, always explaining carefully our reason for these suggestions. The plan worked surprisingly well. Several of these patients were at least partially adjusted to their community environment; one was to be sent to Norway to rejoin his wife and little girl, and three or four, on reëxamination, after they had been under supervision in their homes, were pronounced by the psychiatrist to be showing no trace of nervous disorder.

There are possibly eight or nine chapters in this country doing psychiatric social work: Cleveland, Cincinnati, Louisville, Detroit, Chicago, New Haven, and several other cities, such as St. Louis, Boston, and New York, where the work has been done spasmodically or by comparatively untrained workers. In Detroit, the work has been carried out along much the same lines as in St. Paul. It was begun in January, 1920, but was temporarily discontinued in January, 1921. A psychiatric social worker was added to the

staff because the chapter decided that it needed a specially trained worker to do the follow-up work on the mental and nervous patients. The number of these patients was increasing month by month, and the chapter had no facilities for treating them. The cases were referred to the psychiatric social worker (1) when the man's discharge showed a mental disability, (2) when the family reported that his mental condition was abnormal, (3) through other agencies, etc. There was no way of being sure that all men coming to the psychiatrist were followed up by the social worker. Otherwise the work did not differ materially from that done in St. Paul. The Detroit chapter has never attempted to supervise cases by correspondence.

In Chicago, psychiatric social work was begun in March, 1921, at the request of the American Red Cross, Central Division. There are three workers, at present handling a total of 87 cases. The work was begun mainly to follow the patients discharged from the hospitals treating ex-service men in Chicago. Later, the department took over the supervision of men discharged from the state institutions and from the Psychopathic Hospital. Very little investigating as a preliminary to getting the man to the psychiatrist has been done so far. As a rule, the men are not referred to the psychiatric social worker until all preliminary investigations have been finished, a diagnosis arrived at, and recommendations made—i.e., the work is mainly after care. Patients are referred through the Red Cross officers in the district supervisor's office, or through the Central Division office, never directly from the psychiatrist. All contacts with the psychiatrist on behalf of the men under social treatment in the chapter are made through the district office. Contacts with the Federal Board are made through the division office, never directly. The psychiatric social worker handles the patient and any problem that affects his health. The regular family case-worker is responsible for the financial care and for the handling of the government claims. The psychiatric social worker spends most of her time in the field, and practically none in the office. Some correspondence work is done.

In Cleveland, the plan is entirely different. There is a

neuropsychiatric department in the chapter, with a psychiatrist in charge of the clinic, assisted by a psychologist and four psychiatric social workers. The clinic was established on the initiative of the chapter, in conjunction with the Home Service Section. The clinic is designed to serve ex-service men, members of their families, and cases referred by other social agencies. The cases are referred through the Home Service Section, and by them to the department. One worker handles the case exclusively, once it is referred to her, but a great deal of the preliminary social investigating is done through the Home Service Section visitors, rather than by the clinic staff. Men taking vocational training are under supervision from the department, and treatment for these cases is mapped out in conference with the Federal Board executive. There is also a considerable amount of hospital social service for the ex-service men done through the clinic, the visitor who does this work being ranked as a part of the hospital force in investigating and reporting home conditions. Little work is done in supervising cases by correspondence.

All of these three chapters just mentioned have been able to refer their cases needing employment to various bureaus for the employment of the handicapped, but none of them has any satisfactory solution of the employment problem. Cleveland is looking forward to establishing a workshop which will serve as a therapeutic measure and will enable a man to take his place in the working world on a low level, when asking him to take a place in normal industrial life would be too severe a demand.

Detroit, like St. Paul, has only a small department. Here the great defect seems to be that all cases are not referred to the psychiatric social worker for investigation. In Chicago, it would seem that lack of direct contact with the psychiatrist, both in sending in data and in receiving recommendations, must be a severe handicap to the work. The work in Cleveland is on such an entirely different basis from that of the other two chapters and from that done in St. Paul that comparison is difficult. The system in itself seems quite ideal, but since the clinic is not under the Public Health Service, it would appear that there might be complications in the

adjustment of claims. However, the plan must certainly make for speed and efficiency, both in diagnosis and in treatment.

Psychiatric social work in a Red Cross chapter occupies the same relation to the care of the ex-service man that psychiatric social work in a charity organization society does to the care of the civilian. Just as the efficiency of agencies dealing with special problems is apt to depend in the last analysis upon the efficiency of the general family-welfare agency, so the efficiency of the Red Cross worker, directing after care by letter or working in a Public Health Service hospital, depends on the work done in the chapter. In the chapter, we get family-welfare problems, desertion, unemployment, and so on. We act as a clearing house, referring special types of problems to specialized branches of the Red Cross, after we have done the preliminary investigating, exactly as the Charities refer unmarried-mother cases, children's problems, and the like, to the agencies equipped to handle these particular problems. When the special problem is solved, the case is referred back again to the general agency, in one case to the Charities, in the other to the chapter. Most cases of disabled ex-service men begin and end in the chapter.

In June, 1921, a year and a half after psychiatric social work had been introduced into the St. Paul chapter, we attempted a survey of the work that had been done. We compared the number of psychiatric patients handled per month with the number of general medical patients handled per month, to see what was the proportion of psychiatric patients to general medical patients. We made the comparison reckoning from November, 1920, since at this time the psychiatric social worker first began doing full-time work with the Red Cross. The following table shows the number of general medical cases, the number of psychiatric cases, and the total of both handled each month from November until June. It also gives the proportion of psychiatric cases handled each month to the total number of cases on which case-work was done. We have not included the number of cases on which only informational service was given. We kept no record of psychiatric cases on which the work was only informational, but we believe that the number of these was negligible.

Cases Handled from November, 1920 to June, 1921

Month	Total	General Medical Cases	Psychiatric Cases	
			Number	Per cent
November, 1920.	902	751	151	16.7
December, 1920.	891	774	117	13.1
January, 1921.	954	853	101	10.6
February, 1921.	963	856	107	11.1
March, 1921.	974	872	102	10.5
April, 1921.	1,008	888	120	11.9
May, 1921.	860	731	129	15.0
June, 1921.	824	704	120	14.6

Next we compared the work done in the psychiatric department from month to month over the period from February, 1920, to June, 1921. We found that the number of new cases per month averaged around twenty, with the exception of the months of August, September, and October, 1920, when the psychiatric social worker was away a great part of the time. The number of cases handled per month jumped from two in March to one hundred and forty-three in October—proof that psychiatric social work for the ex-service men was needed and its value appreciated. From January, 1921, to June, 1921—that is, since the chapter has employed its own full-time worker—the total number of cases handled each month averaged about one hundred and ten. We also compared the number of visits each month with the number of office interviews, and found that in those months when the office interviews ran high, the number of visits dropped and vice versa. This meant that we had managed to strike a balance between the two, and we believe it was our flexible methods of handling the work that enabled us to do this.

We had never classified our social data by diagnoses, since similarity of disease does not presuppose similarity of treatment, but we were able to draw up a table showing the frequency with which the various diagnoses appeared. This table is interesting, as it shows the preponderance of the diagnoses of neurasthenia and dementia praecox. During the war a large proportion of the mental and nervous disorders among the soldiers, both in the British and the American forces, were given one or the other of these two diagnoses.

Diagnoses of 398 Cases of Mental and Nervous Disorder, Referred to the Psychiatric Social Worker from February, 1920 to July, 1921

Diagnosis	Number
Syphilitic conditions	35
Epilepsy	31
Nervous condition secondary to cerebro-spinal meningitis	7
Nervous condition secondary to encephalitis lethargica	4
Psychosis due to drugs	4
Constitutional psychopathic inferiority with psychosis	6
Neurasthenia	123
Functional neurosis	9
Anxiety neurosis	2
Hysteria	4
Psychoneurosis	6
Manic-depressive psychosis	5
Dementia praecox	88
Alcoholic psychosis	2
Melancholia	3
Neurologically negative	34
Unascertained	23
Mental deficiency	9
Mental deficiency with psychosis	3
Total	398

The success of our work was first attested when the chapter employed a worker at its own expense to take over the care of the mental and nervous cases, when the Anderson Fund worker resigned, and, in addition to this, detailed one of its regular staff to assist in the visits as well as in some of the office interviews. This meant that the work was not only established, but an essential part of the organization, so that the executives of the chapter felt that it must continue, even though this meant considerable expense to the chapter. Using an untrained assistant worked out well, and the chapter will probably continue to detail one visitor to handle mental and nervous patients under supervision.

The work in the chapter is psychiatric social work plus all the contacts that it is necessary to make for the government patient with the Public Health Service and with the Federal Board for Vocational Education.[1] This is only a form of coöperation with other agencies already in the field, but it is such a specialized coöperation that it deserves separate mention. In the field of government contacts, we are beginning to

[1] See note 1, page 313.

see results. Several claims that had been pending for a long time were settled by submitting long, careful histories to the Bureau of War Risk Insurance through the district supervisor's office. One claim had been pending for almost three years and had been disallowed twice, but was very satisfac torily adjusted after the history was sent in with a report of the last examination. A history, backed by affidavits to establish its truth, is a convincing piece of evidence, but it takes time and patience to get this proof, and it is not always possible to get it.

We obtained the interest and coöperation of the Public Health Service in asking for histories on all the mental cases, and in giving thorough and frequent medical treatment to some of the cases on which we were doing our most intensive social work. We were practically always able to secure a psychiatric examination for men whom we suspected of having a nervous or mental disease. Many men who would otherwise not have come to the attention of the psychiatrist were brought to him, through the general clinic, by the psychiatric social worker, who came in contact with them when they filed their claims, or as she went about in the community and heard of them from their families or friends.

We were not successful in our contacts with the Federal Board. This was partly due to the newness of the idea that the mentally handicapped could benefit by training, and partly to the fact that the Federal Board was undergoing considerable reorganization during this last spring. If it were possible for the psychiatrist and the Federal Board executive to have direct contacts, as in some cities, much could be accomplished in a short time that takes a long time when the social worker has to act as middleman between the Federal Board and the psychiatrist. One whole process could be cut out by direct contact between physician and executive. However, without the social worker to act as intermediary, many of the cases would not have received the medical treatment that they sorely needed, and to which they were entitled.

In addition to connecting the ex-service man with the Bureau of War Risk Insurance, the Public Health Service, and the Federal Board for Vocational Education, which is a function of any social worker handling the case of a compensable

ex-service man, the psychiatric social worker has also the following functions which are peculiarly her own:

I. To facilitate admission to hospital or clinic and continuance of treatment.

II. To bring to the physician personal and social data helpful in arriving at a diagnosis and in outlining treatment.

We combined these two functions by seeing that histories on as many mental and nervous cases as possible were sent to the psychiatrist through the general clinic. That we could is due to the organization of the Public Health Service, where every man must first be referred to the general medical clinic before being referred to a specialist. Many of our patients had already been through the general medical clinic and had been reported there as "organically sound, able to resume former occupation".[1] Later, they came into the Red Cross applying for relief, because they were "too nervous" to work. Such cases were referred to the psychiatric social worker, who took a history and referred the patient back to the general medical clinic, with the history. Certainly we expedited the referring of many men to the proper clinic, and through the histories aided both the psychiatrist and the general practitioner in mapping out treatment for them.

III. To assist in carrying out treatment.

Where we failed in the social treatment, the failure was primarily due to pressure of work. We had the facilities at hand, in the way of clinic and hospital, and we had means of following up the cases to see that they received the treatment recommended, but we often did not have the time to do it. This is righting itself, however, as the work gradually becomes better established and results are attainable with less effort. The unusually close contacts that we established with the psychiatrists gave us the chance to assist in carrying out the treatment that they recommended. When the psychiatric social worker first began, she voluntarily did much social work, before the psychiatrists asked for it. At present, the

[1] That so many of the men did slip through the general clinic is no criticism of the clinic staff, since the large majority of the patients gave the examining physician no account of their symptoms. They presented themselves silently for a physical examination, thinking that compensation would be automatically awarded to them. When asked how they felt, many answered, "All right."

psychiatrists expect their routine recommendations to be followed up and are constantly expecting more and more work to be done. What we offered to do at first, or did voluntarily, is now expected of us as a matter of course, and more besides.

IV. To interpret hospital and clinic to patient, family, and organizations of the community.

This, being an educational job, was one of the biggest among those that faced the psychiatric social worker. With the patients we adopted an attitude of perfect frankness. We could not run the risk of their believing that we had tried to hide from them that they were being referred to a "mental" clinic. Our belief that this was the best way to interpret the clinic, and to get the patient in to see the doctor and later to accept hospitalization, was justified. Out of 398 cases, covering a year and a half, we failed only twice to get the patient to the clinic; one of these patients was committed almost immediately by the civil authorities, and the other was declared committable by the physician when he visited the patient at his home. Both were described by the examining physician as "highly resistive and antagonistic". We used the same attitude toward the family, and in many cases induced them to see that the patient was regular in reporting to the physician. In dealing with the other organizations in the community, we had some difficulty. The work was new, its aims were not clearly understood, and the other social agencies were wary in accepting it. But by "cultivating common sense"[1] we showed that the work was neither occult nor mysterious, and practically always won our point when we were trying to map out treatment for a patient with another agency.

It seems as if in a very short time there will be considerable public education done along the lines of mental hygiene. A mental-hygiene committee has been formed, since the first psychiatric social worker went to Minnesota in 1920, in both Minneapolis and St. Paul, looking toward the formation of a state society for mental hygiene. The aim of both of these committees is the education of the public in the problems of

[1] See *The Minimum of Medical Insight Required by Social Workers with Delinquents*, by C. Macfie Campbell. MENTAL HYGIENE, Vol. 4, July, 1920. p. 520.

mental and nervous diseases, and a joint discussion of difficult mental or nervous patients. The committees are formed, in each case, of the executives of the leading agencies in the city. The committees meet every two weeks as a rule. In addition, there will probably be a psychopathic hospital built in a few years, which will form a center for educational work.

V. To make social investigations contributing to medico-social research.

We have done nothing along this line.

To summarize briefly, a year and a half ago psychiatric social work was started in the St. Paul Chapter of the Red Cross, by a half-time worker whose expenses were paid by an outside agency. At present, it is being carried on by two full-time workers, employed by the chapter itself. It has developed rapidly, proving itself of definite value in straightening out government claims and facilitating medical and social treatment of mental and nervous patients among discharged ex-service men. The period of pioneer work is past, and the period of development and expansion has begun. It is too soon to say, but we believe that the work is firmly established on a good working basis, which allows for growth and added usefulness.

ONE HUNDRED INSTITUTIONALLY TRAINED MALE DEFECTIVES IN THE COMMUNITY UNDER SUPERVISION

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THE subjects of this investigation were not a selected group; they were studied because they were within easy reach of the school, and, not having been discharged, were still under its control. They had been allowed to return to their homes either because their parents or friends had asked that they might go "on trial", or because they had been taken home on vacations and, securing work, had for that reason been put "on trial". Two of these boys had "run away" from the school and had later been allowed to go on the list to report. Seven had been allowed to go out and take positions because it was thought that they were sufficiently trained to be self-supporting.

At the present time ninety-seven of the one hundred boys are living in the community. The school, by means of its follow-up system, has kept in touch with them. Some of them have excellent homes and require little supervision, but others, less fortunate, require constant oversight. Nevertheless, all are required to report at the school at regular intervals.

The group of seven referred to above, who are alone in the world, have been placed at work and are rooming in respectable lodgings. All except one of these seven have made friends and are pleasantly situated, but the seventh has not been so fortunate. He went out four years ago, before supervision began, and fell into the hands of unscrupulous people, who, although they did not lead him into any actual wrongdoing, fleeced him of all his earnings. When he was located, he was placed in a different environment and is now doing well.

Three of the one hundred boys have been returned to the school: one for committing an indecent assault, another because he either could not or would not keep a job and his

people wished his return, and the third—a young boy whose training is not yet completed, and who lost his job during the recent business depression—because his people wished him to have further training.

Of the extra-institutional cases still in the community, five are young boys with a fairly high I. Q. who are living at home and attending the public schools. Two other boys with a mentality of less than eight years are doing farm work at home. One boy, twenty-four years old, has a mental age of less than eight, and in addition is hemiplegic. He is unable to hold a position; he is, however, able to be of much assistance in housework at home. Another boy has a six-year-old mind and can do little that is of economic value, although he is of some assistance to his people. Two boys are in the army, one in the navy, and another is taking the government vocational-training work. Four boys are out of work because of the hard times. These four are living at home and are closely supervised by their people. Two boys have been sent to reform schools. Notwithstanding the present scarcity of work, and the fact that a number have had to find new jobs, seventy-eight boys are working and are self-supporting, although many of them have been reduced in pay or have had to take inferior positions.

An investigation of the conditions that led to the commitment of these boys showed that forty-five were admitted to the school through the courts for misdemeanors of a more or less serious nature, or because their antisocial traits and acts had so disturbed their relatives that they felt something must be done. Perhaps the most serious case was that of a boy with a nine-year-old mind who got into bad company and, following the example of his associates, who were older, drank heavily. One night, in trying to get money out of a gas meter in order to buy more liquor, he broke the pipes and gas escaped, killing his crony, who was lying in a drunken stupor. This was so serious an offense that only after much deliberation did the courts decide to consider the boy not responsible for the act and to send him to the school, where he remained a long time. His drinking had been due to the example of his low associates rather than to any strong desire for liquor. While at the school this habit sank into the background, and

he established habits of quiet, orderly living and industry. About three years ago he was allowed to go home "on trial". His people now understand the situation and are giving him excellent supervision. He works steadily and earns thirty dollars a week, which he gives to his mother. He is not spending his evenings on the streets and so has not drifted back to his old habits and acquaintances. He goes out with his brother to the "movies" or theaters, and is faithful in his attendance at church.

Twenty-five of the hundred were admitted to the school because their parents wanted them to have the advantages of the training at the school; twenty were admitted through the efforts of social agencies working throughout the state; and ten came through the efforts of hospitals or doctors. The boys entered the institution at various ages, but most of them were brought when they were young, eight or nine years old, stayed until they had passed the adolescent period of unrest, and went out at nineteen years of age or more.

The range of wages for the group under eight years mentally runs from $8.00 to $26.00 per week. There is no outstanding peak of wages for this group. One boy is a helper on a freight truck at $26.00 a week. Three are earning $24.00 a week—two as helpers on a truck and one as a roofer's helper. One has been getting $22.00 a week in a manufacturing plant, but he has within the last few days joined the navy. One is earning $20.00 a week learning the upholstering trade; three are getting the equivalent of $20.00 a week, one as a helper in a restaurant and two as farm hands. Two work on milk wagons and one on a peddler's wagon for $8.00 a week. The others are helpers either in factories or on farms.

The range of wages for those with eight-year-old minds is from $10.00 to $28.00 a week, the latter wage being earned by a boy who is a fire tender in a roundhouse. One receives $24.00 a week taking boards from a saw in a lumber yard. Of those earning $20.00 a week, one repairs automobile radiators and one nails boxes in a chocolate factory. In the $18.00 a week group, one is a boiler maker's helper, one repairs furniture, and two help on machines. One earns $16.00 as a stitcher in a tailor shop. Four others do rough work in factories and receive from $10.00 to $16.00 a week. Two are farm

hands receiving $20.00 a month and board; one works in a stable for $10.00 a week; one gets $14.00 as an errand boy; and one sets up pins in a bowling alley for $10.00 a week.

The range of wages for those with nine-year-old minds is from $12.00 to $30.00 a week. Of the two getting $30.00 a week, one is a painter and the other a machinist's helper. One packs glass at $28.00 a week, and one is an elevator boy at $18.00 a week. The others work either in factories or on farms.

The range of wages for those with ten-year-old minds is from $10.00 to $32.00 a week. One is an employee on the railroad at approximately $32.00 a week. In this group are those who drive teams and trucks. One is an errand boy in a bank, one works in a private office, and one is a canvasser.

Of those over ten years old mentally, the range of wages is from $10.00 to $34.00 a week. One is "directing stock" in a factory and has seven men working under him. This boy's history is interesting. Before entering the school he was a sex offender. When he was seventeen years old, he was allowed to go out, although against advice, but soon had to be returned to the school for the same offense. While at the school the second time, he was a leader among the boys and seemed to get better control of himself. He went out again when between twenty-two and twenty-three years of age, and went into a manufacturing plant as a helper. At that time he exhibited a great deal of ambition, wanting to accomplish something in the line of earning money. He also wanted to be respected and looked up to by other people. While he was a helper in the shop, he attended night school and in every way tried to emulate his older brother, who was attending one of the colleges. He was always pleasant and courteous in his manner and made friends easily. He was gradually promoted until, during the peak of high wages, he earned from $42.00 to $45.00 a week on piece work. When the business depression came and men were discharged, he was put in charge of a certain simple part of the work with seven men under his direction. His pay, however, was reduced to $30.00, which he is now receiving.

In this same group of over ten years mentally there is a truck driver at $30.00 a week and a painter at $26.00. One

boy is turning eggs in a hatchery; one who is nearly blind is a broom maker. A sixteen-year-old boy is making $10.00 a week as an errand boy. Several boys in this group are doing factory work.

It is noticeable that with the increase in the mental age, the wage earned by the greatest number increases—that is, of those with eight-year minds the greatest number are earning $18.00 a week; of those with nine-year minds the greatest number are earning $20.00 a week; of those with ten-year minds the greatest number are earning $24.00 a week; and of those with a mentality of over ten years the greatest number are earning $26.00 a week.

The minimum wage in each group was found to be as follows:

Those with less than an eight-year mind earn a minimum of....	$8.00
Those with an eight-year mind earn a minimum of.....	10.00
Those with a nine-year mind earn a minimum of.....	12.00
Those with a ten-year mind earn a minimum of.....	10.00
Those with over a ten-year mind earn a minimum of.....	10.00

The drop to a minimum of $10.00 a week in the groups of ten years and over ten years mentally is probably due to the fact that in these groups are boys who are chronologically younger and who therefore do boys' work.

With regard to the maximum wage, the findings were as follows:

Those under eight years mentally receive a maximum of.....	$26.00
Those eight years mentally receive a maximum of.....	28.00
Those nine years mentally receive a maximum of.....	30.00
Those ten years mentally receive a maximum of.....	32.00
Those over ten years mentally receive a maximum of.....	34.00

The fact that in the group of less than eight years of age mentally there are as many earning $24.00 a week as there are earning $8.00 may be due to the fact that those earning $24.00 a week are hod carriers, roofers' helpers, or workers doing similarly hard or dangerous work, and are, therefore, paid more. These same scales have since been worked out with twice this number of boys and show practically the same results.

The range of the kinds of work is as wide and as varied as the range of wages. Of course, the younger boys, chronologi-

cally—from fifteen to seventeen years old—are doing young boys' work; that is, they are messenger boys, office boys, errand boys, bundle boys, helpers in shops, etc. Some of these younger boys have ten- or eleven-year-old minds. In the right environment and under the proper supervision, they may become good workmen, and may earn as much as the older boys of the same mental age.

It is interesting to watch the progress of these younger boys. When they first go out, at about fifteen years of age, they get the least important parts of the work and earn from $6.00 to $10.00 a week. By the time they are seventeen years old, they are earning from $12.00 to $15.00 a week. They often succeed in the same place in which they begin, their faithfulness bringing them promotion. The young tailor is an interesting example of this. At fifteen years of age, with an I. Q. of 75, he went to work in a tailor shop as an errand boy, starting at $4.50 a week. At the end of a year, his pay being increased gradually, he was earning $10.00 a week as a "bushler". Later he learned to press at $12.00 a week, and in a few months was a presser at $14.00 a week. Now, at seventeen years of age, he is learning the stitcher's part of the trade and is earning $16.00 a week.

Probably the largest group of boys at work is made up of laborers and helpers in factories. They can run simple machines and do automatic work that does not require much intelligence. During this last winter a boy with a mental age of six years and ten months worked as a laborer for a contractor, earning $29.76 a week. Much of the time he mixed lime and carried a hod. In a family with a number of normal children he was the only member working and his money supported the family. This boy came to the school, at the age of twelve years, a quick-tempered, excitable imbecile; he went out at the age of eighteen years quiet, obedient, and with some degree of self-control. While at Waverley he received very careful training in the only kind of work that his mentality enabled him to do and went directly from the school to his job.

Another fair-sized group is successful at farm work. They are willing, faithful plodders, and though they may not like to get up early in the morning, they do not, as a rule, think of

objecting, but take it as matter of course. A number of boys are helpers on trucks and teams, while one or two do the actual driving. Milk wagons also furnish a place for one or two of them. There is also such work as lifting boxes, pushing trucks, sweeping floors, etc., for which industry can use the trained feebleminded. Many of the boys are doing work that they were trained to do while at Waverley; for example, some of them are employed as helpers in the kitchens of restaurants and lunch rooms, others are helpers in storerooms, and still others are painters.

That these boys are a success is due to the fact that they are faithful, conscientious, methodical, unquestioning workers. While at Waverley they were trained to work steadily and faithfully and to take pride in their work. They are painstaking with uninteresting details of their work, and it matters not how simple it may be, they take pride in doing it well. True, this pride needs to be stimulated by the interest shown by some one in authority. With this interest and a bit of praise, the boys take pride in digging a ditch with smooth, even sides, or in packing bricks into a hod firmly and evenly. They will do the same thing in just the same way day after day, and they will work until the bell rings. They seem to enjoy the monotony instead of tiring of the repetition. As a rule they will take a direction—if they understand it—and will follow it without questioning or stopping to debate whether it is really their job or whether it belongs to some one else to do. They do what is expected of them. They will be there at 7 a. m. and will not stop to reason whether eight o'clock would be better. If they are expected to work overtime an hour, they will do so, and if questioned as to how they like to work long hours, they usually reply, "I don't like to, but you know the boss wants to get this job done, and he can't if we don't work for him, and anyway he gives me some extra money for working overtime." If they can only be made to feel that they are expected to do a certain thing, there is something compelling about this feeling, and they do the expected thing.

Another great reason for their success is that these boys crave respectability. It is almost pitiable to see how they long to be looked upon as other men are, and to be thought of as

"somebody". Many of them come from poor homes—homes that have been supported by charity and visited by the police. Before coming to the school, they have felt the sting of scorn because they were slow in school and at play. They were ignored and therefore practically ostracized because they could not "keep up". The joy and satisfaction they show at having any one notice and praise them, either upon their appearance and conduct or upon their savings or work, is strong evidence that the love of approbation is a great factor in their success. Now that they have what they call a "chance", they exert every effort to suppress their unfortunate traits and habits, as they had been trained to do while at Waverley. They try not to let their fellow workmen know that they have been at the school or that there is anything going on that they do not understand. Some of the more intelligent ones get the reputation of being reserved because of their quiet withdrawal when the subject of discussion is beyond their comprehension. They try so hard to be and to act like their fellow workmen that with constant encouragement they succeed fairly well.

While at the school, they were taught the desirability of cleanliness. The officials of the school become their ideals of respectability and they want to be as well dressed and as well thought of as these officers. It is no uncommon thing to have a boy, when he first goes out, write at the end of the first month and say that he cannot report that first Sunday because clothing is so high that he hasn't been able to get all that he wants, and if he must come, can't he come early Sunday morning or on Saturday afternoon, when there will be no other boys there? Unless it is a boy about whom there is some uncertainty, he is allowed to wait until the second month to make his first report, for we have grown to realize how much this first report and the new clothes mean to him. Of course, the boys leave the school neatly and sufficiently well clothed, but this first new outfit seems to be an expression of their longing to be like others and to be respected. They almost never get clothing that is flashy. Either their native taste is good or else, in buying clothing, they get things that are as nearly as possible like those worn by people who have been their ideals.

While at Waverley, they are taught to save. They hear of bank books and look upon the possession of one as a sort of open sesame to higher levels of society. Therefore, following closely the new clothes, comes the bank book, and they are fairly steady savers—with encouragement. One often wonders if they actually appreciate the value of money. It is something that they have never had much of and for which they have little use. Now, all at once, they are getting what to them is a large amount. After they get the new outfit and their board is paid, they find that they have some on hand. They put this remainder in the bank because "respectable" people do and because they are advised to do so by the school. Few of them have any real idea of the necessity of saving. In fact, it does not seem as if one of them realizes that this money will be of great help to him in a time of need.

Few of them want, or expect, excitement. They are satisfied with the "movies" once or twice a week, and an occasional visit to the theater. Seven of them attend dances, but not one of them takes a young lady with him. They have selected reputable places and leave at a fair hour. Many of these boys are still interested in baseball, gymnasium work, and other athletics of various kinds. Most of them play on some neighborhood ball team. Swimming also is a source of great enjoyment to them. Many of them are interested in their church, and are faithful in attendance. Small groups of them go for long walks on Sunday, while many of them enjoy walking up and down the streets looking into the shop windows, especially clothing-store windows. Some of them have bicycles and get real enjoyment from them. On the whole, their evenings are short, and most of them are spent at home with a Victrola or games, or with books and papers, usually closing about nine o'clock.

The following stories of two boys will show what is meant by some of the traits mentioned above.

Tom is an illegitimate child who has no relatives and knows nothing of his ancestry. He was committed to the State Board of Charities in 1901, and came to Waverley in 1914, being committed to the school by the Overseers of the Poor. He had done no real harm, but had been unable to fit into any of their

boarding homes. The only question of misconduct at that time was drinking. While at Waverley, he exhibited few bad traits. He was friendly, quiet in his manner, fond of outdoor games, of military drill, and the like, but did not enjoy reading. He was fond of clothing, and, when opportunity offered, would appropriate articles belonging to other boys. In July of 1918, he went out "on trial". At first he went to work as a teamster, earning $3.00 a day. He soon took up the habit of smoking and chewing, but did not again use liquor. At the end of a year and a half he was earning $20.00 a week and had saved $205.00, some of which was in Liberty Bonds. In April, 1920, when he reported, he was earning $21.00 a week. He had been ill for two months and had spent all but $25.00 of his savings. Up to this time, he had saved as most of the others do, simply because it was thought to be the correct thing to do. Now he shows a keen interest in his bank book and is proud of the fact that he was able to be self-supporting during his illness.

Billy was born in 1896. He was admitted to the school in 1905 and went "on trial" in 1915. He has a mentality of 9-4. He came with a history of insanity in his family. At first he was sly, dirty, and apt to take anything that he thought he wanted. He was saucy and disobedient and was always trying to do something different from other people. He exhibited bad sex habits and was untruthful and selfish. Bill was in the school for eleven years, during which time he overcame these undesirable traits to a great measure. He became a slow, plodding boy, and although he instinctively felt the same inclinations, he at the same time recognized the undesirability of allowing himself to exercise them. He went out "on trial" to live with his mother and grandfather. He spent his evenings at home, and according to latest accounts, had beaten his grandfather 10,005 times at checkers, while his grandfather had beaten him only 3,025 times. His having played so many games of checkers in four years may account for his keeping out of trouble. Upon leaving the school, he went to work in a factory at $9.00 a week. Later in the same year, he went to work for one of the meat-packing places at $12.00 a week and began to save at the rate of $1.00 a week.

Perhaps all the credit does not belong to Billy, as he turns most of his money over to his mother and she superintends the saving.

Of the one hundred boys of this study only three have been arrested. One was returned to the school, and the other two were sent to reform schools. With the exception of the one boy returned to Waverley, none of these boys has done anything of an immoral nature. All but two of the adults in this group have been self-supporting and most of them have helped in the support of their families. It is noticeable that after a boy's training has made him an asset to his family, his people become interested in him and coöperate in his supervision.

The school does not handle the boys' money in any way, though it does advise, and to some extent direct, in the matter of the use of their money. Neither does the school deal directly with the employers. In only four cases, where the boys had no people, were the arrangements made for them. On the whole, it seems to work out better to allow the boy, or his family, to make the contacts and obtain the position.

These one hundred boys have been living in the community for from ten months to five years. Most of them have been out of the school between two and three years. At present, when the pressure for admission of young, teachable boys is so great, this community supervision for older, trained boys makes it possible to admit those who so much need this training and who otherwise might become delinquents.

This brief study shows that, with few exceptions, these boys have made good. Their success seems to be due to the painstaking, constructive training received while at the school and to proper supervision after going out into the community. We feel that, with continued friendly, helpful supervision, free from humiliating circumstances, the average feebleminded boy, properly brought up and trained to work, can live in the community and play his part there.

THREE HUNDRED PSYCHIATRIC EXAMINATIONS MADE AT THE WOMEN'S DAY COURT, NEW YORK CITY

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IN the fall of 1920, the New York Probation and Protective Association, an organization that is intensely interested in the welfare of the girls and young women of New York, offered the part-time services of a psychiatrist to the Women's Day Court. It was not the purpose of the organization to undertake a survey or to carry out a statistical investigation. The idea was simply to gain an impression of the psychiatric material that presented itself in the court cases, to see whether a psychiatrist could be of service in helping the court and in aiding the probation officers in the handling of special problem cases. It was also the hope of the organization that the examiner would be able to help the individual girls to arrive at a better understanding of themselves and their difficulties. The work was begun on October 17, 1920, and was carried on until August 15, 1921; during these ten months 300 women were examined.

On account of the variety of the material, it was difficult to find a way to group and handle the records. For the purpose of discussion, the simplest plan seemed to be to classify the cases according to the nature of the charges made against the women, but doing away with technical terms.

The following table gives the groups with the disposition made at the time of examination:

Charge	Total	Dismissed	Placed on Probation	Sent to Institutions
Incorrigible	114	9	49	56
Prostitution	160	..	47	113
Disorderly conduct	6	1	1	4
Vagrants	6	2	2	2
Larceny	2	..	..	2
No formal charge	12	..	..	12
Total	300	12	99	189

Under the heading *prostitution* are included those arrested for committing or offering to commit prostitution; also those arrested for soliciting or violating the Tenement House Law. These, with the group of incorrigible girls, make up the mass of the material—that is, 274 of the 300 cases. The other groups will be disposed of briefly. Those termed *disorderly-conduct* cases and *vagrants* are not prostitution cases. Excepting one larceny case, the women came from other courts, but were held in the Jefferson Market Prison, and the examinations were made at the request of the probation officer who conducted the investigation. Of the six disorderly-conduct cases, two were insane and one was a chronic alcoholic. Two of the vagrants were insane. One of the larceny cases was seen at the request of the magistrate because her behavior was abnormal. She was found to be insane. The other larceny case was seen at the Tombs at the request of a probation officer from the court of general sessions.

The twelve women against whom no formal charge was made were referred cases. Two of them were witnesses; two were girls suffering from venereal disease who were brought by policewomen; two were referred by the probation bureau; five came from the Florence Crittenton Home; and one was a young woman sent from the Domestic Relations Court, where she had made a charge of non-support against her husband.

Of the cases sent to institutions, 104 were sent to the Kingston Avenue Hospital for the treatment of venereal disease. Sixty-six of them were prostitution cases. Thirty-six women were sent to the House of the Good Shepherd, nineteen to the workhouse, five to the New York State Reformatory at Bedford, eighteen to the Psychopathic Ward of Bellevue Hospital, two to the House of Mercy, and five to various institutional homes. In all, 138 of the 300 women had gonorrhea or syphilis or both, for many of those sent to the House of the Good Shepherd, to the workhouse, and to Bedford Reformatory were diseased. Fifty-five per cent of the prostitute group were diseased and 36.8 per cent of the incorrigibles had been infected.

The questions most frequently asked when one is discussing the work are: "How many of the girls are normal?" and,

"How many feebleminded do you find?" These questions are not so easy to answer, though it seems that one should be able to reply concisely with a few figures and percentages. The first question, as to how many of the girls are normal, will be taken up later in a discussion of a group of those who are normal in intelligence, but who present most difficult conduct problems. By the inquiry, "How many are feebleminded?" the questioner usually means how many should be sent to institutions for mental defectives. The lay person does not realize that institutions cannot possibly care for the great number of feebleminded or that many of the high-grade defectives can get along perfectly well in community life. With our institutions full, it is a matter of considering each individual case, seeking commitment only for those in the greatest need of protection—protection for themselves and protection for society against the spread of venereal disease and the reproduction of their kind—and seeking a suitable environment for the others. This means a study of the girl's sex proclivities, habits of industry, personality traits, and capacity for adapting herself to others. For example, one feebleminded girl was quite a good worker and fond of children, but she was subject to uncontrollable fits of temper, at which times she was actually dangerous; she was, therefore, committed.

The Intelligence Tests

It was not possible to give all the women intelligence tests. A few refused to coöperate, some did not speak English sufficiently well, others were hurried away before the examination was completed, and there were a number of women suffering from mental disease for whom such a test would have had no value. Two hundred and seventy-six of the women, however, were tested by the Terman intelligence test. The following table gives the results:

Charge	Total		Normal		Dull Normal		Border-Line		Defective	
	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
Incorrigible	107	100.0	16	15.0	29	27.1	33	30.8	29	27.1
Prostitution	149	100.0	28	18.8	37	24.8	46	30.9	38	25.5
Others	20	100.0	4	20.0	4	20.0	8	40.0	4	20.0
Total	276	100.0	48	17.4	70	25.4	87	31.5	71	25.7

For the whole group examined, the normal and dull normal constituted 42.8 per cent, while the border-line and defective together were 57.2 per cent; for the incorrigible group, the corresponding percentages were 42.1 and 57.9; and for the prostitution cases 43.6 and 56.4. This table shows that 17.4 per cent of the 276 cases tested have normal intelligence, which is expressed by an intelligence quotient of 90 or above. This means that they pass successfully the tests required of a normal child of the age of fourteen years and five months. The next group, the dull normals, make up 25.4 per cent of the cases. These individuals, with an intelligence quotient of 80-90, correspond in mental capacity to children of the age of twelve years and ten months to fourteen years and five months. The so-called border-line cases, 31.5 per cent of the series, have the mentality of children of the age of eleven years and four months to twelve years and ten months. Those termed mental defectives have an intelligence quotient of below 70—that is, in the tests they can compete mentally only with children less than eleven years and four months. Over one half of the cases—57.2 per cent—therefore, are defective or subnormal in intelligence. Five of the 71 defectives had actually been in institutions for the feebleminded. For the low-grade defectives, or for those who showed marked sex delinquency, admission to custodial institutions was recommended. Such a case is given in the following record:

> *Case 1.* This girl of nineteen began to have relations with boys before she menstruated, and before fifteen she was going with men and accepting money. Three years ago she had a still-born child and last July she had another. Her mother was dead, and her father worked at night, so that it was easy for her to bring men to her home. Her mental age was 8.6 years. She was treated at the Kingston Avenue Hospital for syphilis; then returned to the court. Because of the necessity of making an immediate disposition, she was sent to the House of the Good Shepherd.

On the other hand, mental defectives with good habits of industry, who are not dominated by the sex instinct, can get along in a protected environment if not taxed beyond their limitations.

Cases Sent to Bellevue Hospital for Observation

When a woman was found to be seriously defective, with vicious social tendencies or mentally sick, an effort was made to have her sent to the Psychopathic Ward of Bellevue Hospital to be observed and from there committed to one of the state institutions. As previously mentioned, eighteen individuals were admitted to the Psychopathic Ward of Bellevue Hospital, but two additional cases who were first observed on probation were also sent there. Of these twenty cases, seven were mental defectives and five of them were committed to proper institutions. One defective was removed from Bellevue by her relatives, who refused to coöperate in the plans for commitment; the other was, through a mistake, dismissed from the hospital. On account of the intricacies of legal procedure, most of these cases were simply admitted for observation on the recommendation of the examiner and were not committed to the hospital by the magistrate. Ten women were considered insane and eight of these were committed to state hospitals for the insane. One of the other two was returned to her relatives in her home state; the other woman was considered committable, but the judge permitted her relatives to take her in custody and she later shot herself. The three women dismissed from Bellevue as not insane or defective represent very difficult problems. One of them will be discussed under the group of constitutional psychopathic inferiors.

This answers directly the question, how many were actually committed—five defectives and eight insane. As a matter of fact, the examiner considered 48, or about one-sixth, of the 300 as utterly unfit for community life. Of these, fourteen suffered from mental disorders (ten mentioned above as sent to Bellevue Hospital, three sent to the workhouse, and one to Kingston Avenue Hospital). All these were serious cases and not hysterias or minor disorders. Thirty-one defectives and three from the border-line-intelligence group complete the list of 48. Two of the border-line cases were sent to the House of the Good Shepherd. The other one, who has the following history, was given probation:

Case 2. This woman was anæmic in appearance and had a goiter that was causing mild symptoms. She was a sickly baby, has always been weak, and is still subject to "bilious headaches". According to her statement, she finished the 8B grade at fourteen, failing in only one grade. Her intelligence level was 12.2, intelligence quotient 76. She had earned good wages, but had not been able to stick to a job long. After she had been deserted by the husband whom she had married at sixteen, she had an illegitimate child. In December 1919, she had another child which was premature and died, and since then has induced two abortions. In July 1920, she married the man by whom she had had the last three pregnancies. He was cruel to her, and she left home to escape him. She was arrested in a hotel and admitted that she had had relations with the man with whom she was found, but she denied soliciting or receiving money. She said simply, "I thought if I could do a favor, I would do it." She admitted that she could not control her sexual cravings and realized that she was easily led. Though her intelligence level is relatively high, she shows certain characteristics of the feebleminded, and her sex life is such that one would consider her a proper institution case.

The disposition of the thirty-one feebleminded was as follows: seven were sent to Bellevue Hospital, nine to the House of the Good Shepherd, six to Kingston Avenue Hospital; five were given probation; two were sent to the workhouse; one, long in prostitution, was sent to the New York State Reformatory for Women at Bedford with the purpose of having her admitted to the defective-delinquent group there. The other girl was one of the witness cases referred for examination. A greater effort should be made to get these feebleminded girls committed to custodial institutions where they can be held indefinitely. They cannot be considered responsible, yet after a few months at the House of the Good Shepherd they will again be at large.

The border-line-intelligence group, which makes up almost a third of the 276 who were given the Terman test, is a most difficult set of girls to adjust to community life. They have an intelligence quotient of 70-80, which corresponds to that of children of normal ability of the age of eleven years and four months to twelve years and ten months. If these girls have stability and good habits of work, they can support themselves in the industrial world. The majority of them, however, are unstable; many of them have the characteristics of the feebleminded—that is, they are suggestible, easily led, the prey of others, as, for example, the case just mentioned (Case 2). When one looks through the border-line group,

one is struck by the great number of serious problem cases. The following record of one from this group will be recognized by court workers as a familiar type of the so-called "incorrigible girl":

Case 3. Marie, aged seventeen, was born in New York. Her father is dead, her mother does day's work, she lived in an orphanage from the age of three to eight. She first attended parochial school, then went to public school, leaving at fifteen in grade 8A. She had failed in two grades. At sixteen she went to work in a factory, but after three months she left to become a telephone operator. After following this occupation for seven months she was discharged, probably for inefficiency, but the immediate occasion was a temper tantrum and a quarrel with a fellow-worker. For six months she has had no work and has idled her time away, reading novels during the day and running about the streets at night, not getting home until two in the morning. She was "disgusted" because she lost her job and did not think it worth while to bother about another. One morning she had a fit of temper and threatened her brother with a butcher knife, because he talked to her about going to work. The mother was obliged to call an officer and brought the girl to court. She was sent to Kingston Avenue Hospital because the routine examination revealed the fact that she had gonorrhea; later she was sent to the House of the Good Shepherd. She had been immoral five months before her arrest, with a man whom she met while strolling at midnight on Broadway. She liked him and went willingly with him a number of times; then he dropped her. This experience made little impression on her, and she did not feel that it played any special rôle in her life. Her mental age is 12.5 years, intelligence quotient 77. Her general health had been good, but she had been nervous from the age of seven to fifteen, restless and jerky, a condition that she described as "a touch of St. Vitus dance". Such nervous instability, temper, fits, indifferent moral attitude, and mediocre mental capacity, are common attributes in the incorrigible group.

The Incorrigible Girls and Prostitution Cases

It must be emphasized again that the work was not undertaken as a statistical investigation. The record in almost every case is the result of one interview with the girl. However, one can glean from these records certain important impressions. Though a girl more often than not gave false information in order to conceal her identity, she was usually willing to coöperate in the intelligence test, to answer medical questions, and to enter into a discussion of her personality, so that so long as one kept to such topics one could gain quite valuable knowledge. In comparing the incorrigible group with the prostitutes, one finds that their intellectual level is practically the same—that is, approximately 57 per cent are defective or subnormal in mentality. We also find that 63.1

per cent of the incorrigibles and 66.8 per cent of the prostitutes did not finish the eighth grade in school; 11.4 per cent of the incorrigibles and 16.2 per cent of the prostitutes entered high school, but did not finish. Among the incorrigibles we had no high-school graduates, but there were five in the prostitute group.

Of the incorrigible girls, 25 stated that they were Protestants, 14 Hebrews, and 75 Catholics. Among the prostitution cases, 56 were Protestants, 27 Hebrews, and 77 Catholics.

In regard to ages, only ten of the 114 incorrigible girls were over twenty-one. The majority of the prostitutes were between twenty and thirty; 143 of the 160 were under thirty-one years of age; one was over forty; and two were under sixteen.

As to nativity, the groups ran about the same; 81.6 per cent of the incorrigibles and 78.7 per cent of the prostitutes were born in the United States. The homes of 19 of the incorrigible group and of 68 of the prostitution cases were not in New York City. The nativity of the two groups was as follows:

Nativity	Incorrigible Girls	Prostitution Cases
United States	93	126
Africa (British)	..	1
Austria-Hungary	1	7
Belgium	..	1
Canada	..	5
Cuba	1	..
Denmark	..	1
England	..	3
France	1	1
Ireland	1	..
Italy	6	2
Norway	1	..
Porto Rico	1	..
Russia	8	7
Sweden	..	1
Switzerland	..	1
West Indies (British)	1	2
Not known	..	2
Total	114	160

In the matter of the number of times under arrest the groups approximate each other: 70.2 per cent of the incorrigibles were in court for the first time, as were 76.2 per cent of the prostitutes. Thirteen of the incorrigibles and six of the prostitution cases had records in the Children's Court.

It must be remembered, however, that many of the prostitutes are out-of-town girls. The following tabulation shows the number of arrests for the two groups:

Number of Arrest	Incorrigible Girls	Prostitution Cases
First	80	122
Second	26	24
Third	7	6
Fourth	1	2
More than fourth	..	6
Total	114	160

When one uses the term prostitute, it must be kept in mind that these were not the old-timers or street-walkers, but younger women of the better type. The incorrigible girl usually lives at home and is brought to court by her relatives, so it is not surprising that only 16.6 per cent come from other places, while 42.2 per cent of the prostitutes are from out of town; many of them have drifted here as chorus girls. We find that only 4.4 per cent of the incorrigibles were chorus or "show girls", but 14.4 per cent of the prostitutes give that as their occupation, and 20.6 per cent of the prostitutes were not working; some had not had a job for weeks or months. Reports on investigations of positions and work records were not available at the time of the psychiatric examination; doubtless many of the others were being supported instead of working.

The occupations of the incorrigible girls and the prostitution cases are shown in the following table:

Occupation	Incorrigible Girls	Prostitution Cases
Factory	45	27
Telephone operator	17	11
Clerical	15	23
Domestic	8	16
Waitress	4	11
Chorus and shows	5	23
Dance instructor	4	3
Usher	2	..
Elevator operator	..	3
School	3	1
At home (married women)	..	10
None	11	33
Total	114	160

The border-line case cited above (Case 3) represents the unstable, neurotic, mentally subnormal girl, characteristic of the incorrigible type. The prostitute type does not so frequently give a history of nervousness and neurotic traits, pointing to a neuropathic constitution. She is lazy, vain, morally lax. She wants the silk stockings and the fur coat and goes "the easiest way" to get them. It is usually not sex cravings, but a placid, indolent nature with a desire for finery, dancing, and excitement, that is back of her sex delinquency. She is exceedingly shallow and empty emotionally; in fact, many of them say frankly that they have never loved any one, that they care for no one but themselves. The high percentage in the prostitute group of "show girls" and girls not working, together with a study of the tabulation of the neurotic traits, confirms the impression that one can sort out different types to represent the two groups.

MANIFESTATION OF NEUROTIC CONSTITUTION

NEUROTIC TRAITS	INCORRIGIBLE GIRLS		PROSTITUTION CASES	
	Number	Per cent	Number	Per cent
Nail-biting	44	38.6	41	25.6
Enuresis (at least to eight years of age)	25	21.9	21	13.1
Excitability, instability	30	26.3	29	18.1
Sleep disorders	22	19.3	13	8.1
Temper tantrums	26	22.8	16	10.0

The distribution of these traits among the individuals of the two groups is as follows:

	INCORRIGIBLE GIRLS	PROSTITUTION CASES
Number having only one of these traits	28	45
Number having two of these traits	25	23
Number having three of these traits	16	9
Number having four of these traits	4	4
Number having all five of these traits	3	..
Total number with these traits	76	81

From the above table one sees that 66.7 per cent of the incorrigible girls give evidence of poor neuro-muscular balance and poor emotional control. This is a decided increase over the 50.6 per cent of the prostitutes that show such traits. One will note, too, that sleep disorders and temper tantrums are more

than twice as common among the incorrigibles; also that the percentages for the other three traits are much greater. The terms of the table need little explanation. Nail-biting, picking at the nails, and knuckle-cracking are evidence of tension. Enuresis (bed-wetting) may be indicative of poor neuro-muscular control, but is frequently a lack of habit training. It is striking how often this habit persists to the age of puberty or later. Under the caption, "Excitability and instability", one refers to such statements from girls as that they have always been considered nervous, that they are easily frightened, that they get excited or "hysterical" at the least little thing; in fact, this heading covers a variety of descriptions of vague states of uneasiness, apprehension, tension, and poor emotional control. Sleep disorders were not recorded unless they were definite and quite marked, such as the habit of sleep walking, repeated disturbing night terrors, and the like.

In addition to the above-mentioned traits, the following conditions were found:

	Incorrigible Girls	Prostitution Cases
Retarded physical development	11	10
Chorea	6	6
Major hysteria	3	5
Speech defect	2	..

Sex and Marital Life

A few facts regarding the sex and marital life of these women may be of interest from the social and eugenic standpoint. Local examination of the 114 incorrigible girls showed that 90, or 78.9 per cent, of them had had intercourse. Two of those who had not had sex relations were perverts. Eleven of the 114 were pregnant at the time of arrest; seven had had an illegitimate child. Eleven of the incorrigible girls were found to have been married, but in only one of these cases—possibly two—could one hope to make anything of the marriage. Seventy-five of the 160 women arrested on a prostitution charge acknowledged frankly that they were promiscuous. Four of the prostitution group were pregnant at the time of arrest; thirteen had had an illegitimate child; and fifteen others had been pregnant illegitimately, five of these confessing to criminal abortions. Eighty-five in the prostitu-

tion group stated that they were single. Of the seventy-five in this group who said that they were married, four were widows and forty-four were separated from their husbands. So one sees that, besides venereal disease, there are very serious social problems to be met in these court cases.

Types of Mental Disorder

It is stated above that ten women considered insane were sent to the Psychopathic Ward of Bellevue Hospital; eight of these were later committed to state hospitals. The diagnoses in these cases were: dementia praecox 4, manic-depressive insanity 4, dementia paralytica 2. But these are not all who showed psychotic symptoms. In outspoken conditions, the judges were ready to send the patients to Bellevue, but in less pronounced states it was difficult to secure observation. Three patients of the manic-depressive type were sent to the workhouse. One young woman, probably a case of dementia paralytica, showed marked mental deterioration, but was sent to Kingston Avenue Hospital for the treatment of syphilis. One only wishes that the subject of mental hygiene had been as much emphasized and its importance as well understood as the question of venereal disease, for venereal disease is really properly and adequately handled. The psychiatrist in the court feels the urgent need of an adequate scheme of personality study and a definition of terms referring to defective and abnormal personalities. The question of affective capacity constantly presented itself. A few of the women were quite definitely depressed, and one felt that their period of inactivity (no job) was a result of this mental state, yet it was strikingly seldom that one got such a mood description as "downhearted", "sad", or "blue", terms so familiar in true depressive states. On the other hand, "disgusted" was a very common reply. This seemed to cover discouragement with a certain feeling of inner dissatisfaction and discontent. While the term has been applied to a group, one feels that though there were many with low affective capacity, there were not many without some affective response. The contact with the women was much too brief and cursory to judge this well. So many excused their sex delinquencies with the explanation

that on the first occasion they were intoxicated; many that they had been betrayed by a promise of marriage. A number had been complainants in rape cases, yet seldom did they offer the early experience as an excuse. One wonders, however, whether such an early experience does not act as an etiological factor. One very important stimulus to the younger girls is the sort of talk they hear in factories. Repeatedly girls have said that they were innocent until they went to work; then the conversations that they overheard made them curious and lowered their standards of conduct. Masturbation was rarely admitted. Doubtless it is less common in these women who are not sexually repressed. As regards general health, the histories were remarkably good. It was also unusual to find the chronic invalid or psychoneurotic type. That no girls were encountered with paranoid tendencies is probably explained by the fact that these court individuals are usually drifters, lacking in aggressiveness and self-assertion. There are no epileptics in the series. The history of one girl's disappearance from home was suggestive of fugue states, but she had no attacks. Her sister was a deteriorated epileptic. There were several examples of major hysteria. A great many women drug addicts go through the court, but they are not the younger women and only one was examined. This woman, seen at the request of the judge, had long been in prostitution.

Women who have several records are, as a rule, not investigated by the probation officers. The judge occasionally referred an older woman to the psychiatrist if she seemed abnormal. There was one woman who was well known to the attendants of the prison and long considered "crazy" by them, yet nothing had been done to eliminate her from the list of recidivists. The psychiatric examination led to her commitment. The following brief report made to the judge gives the main facts:

"According to the finger-print record, this woman has been convicted in this court thirteen times the last ten years for prostitution. She shows marked speech, memory, and writing defects, all symptoms of dementia paralytica. In manner she is euphoric, boastful. Some of her delusions are as follows: she is the richest woman in the world; she is married to

the son of the King of Saxony; Rockefeller and Roosevelt are her uncles and Katherine B. Davis is her aunt. She denies hallucinations. In the memory test there are many foolish discrepancies. She gives her age as thirty or thirty-six, but states that she was born in 1914. She is not oriented as to time, is unable to give the month or the year, but states that it is wintertime, about Christmas. She cannot give a consistent account of her life—in fact, is quite demented, and state-hospital care is urgently recommended."

Normal and Abnormal Personalties Types

Though a well-balanced mental defective or an individual with border-line intelligence may succeed admirably in a favorable environment, in this discussion of normal and abnormal personality types we shall assume that the person shall have a mental capacity equal to that of a child of twelve years and ten months or above—that is, an intelligence quotient of 80 or above. We have taken the records of the women of the incorrigible and prostitute groups of this mental level, the normals and dull normals, and have studied the 110 cases with reference to personality traits, adaptability, nervous instability—that is, the presence or absence of neuropathic symptoms—the capacity for natural affection and adequate emotional response, the instinctive sexual demands, habits of work, and the presence or absence of pathological reactions. With these points in mind, we sorted the individuals into gross types according to the table given below.

Type	Total	Incorrigible Girls	Prostitution Cases
Normal	30	17	13
Constitutional psychopathic personality	7	4	3
Constitutional psychopathic inferior	30	12	18
Constitutional affective defective	43	12	31
Total	110	45	65

The insistent question as to how many of the girls were normal came to be an annoyance, but one could easily counter with the reply, "Give me your standard of normality." The psychiatrist accepts the fact that there are varying standards of normality and is soon lost in the study of the individual and

his assets and modes of reaction and self-expression, not as compared with any theoretical standard, but with reference to the question wherein this person, with his particular equipment, is making a failure. From the standpoint of conventional behavior, one could say offhand that all of these women are abnormal, since they have deviated from social standards and have broken the laws that regulate social conduct. Probably most people mean by the question, how many have the capacity to make a successful social readjustment. Various case records from the thirty individuals of the normal type will be given to show the wide range of personalities within the group.

Case 4. Anna is a sixteen-year-old girl who lived with her married sister in a very good home. Her mother is insane and was committed to a hospital six years ago. Anna was then ten years old, and she lived in a Catholic institution until one year ago. She had had no serious illness and no neuropathic traits. She finished the eighth grade in the parochial school, became a telephone operator, and has worked steadily, earning a good wage. Four weeks before being brought to court on a charge of incorrigibility, she had a quarrel with her sister about her hours and her recreation. She felt that she could not be in by eleven o'clock at night; therefore she ran away and took a furnished room. She was "crazy" about dancing and went out every night. She was going about with a man whom she met at a dance hall and was planning to go to Atlantic City with him, where he had promised to get her a better job. But the night before her departure she was arrested by a policewoman who had been searching for her. The girl was talkative, lighthearted, pleasure-loving, with no realization of the danger she had been in. Her mental age was 14.3 years, I. Q. 89, and she had no special difficulties except an undisciplined temper and a craze for dancing. Examination showed that she was a virgin and she was remarkably free from curiosity and ruminations about sexual matters.

Case 5. Mary is an eighteen-year-old girl from a neighboring city, one of the prostitution cases. According to her story, she was on Broadway when a man came up and asked her to take a ride, offering her five dollars for a good time. She was arrested as she was getting into the taxicab. She stated she did not intend to prostitute, that she thought she would have a gay evening, but did not intend to yield to intercourse. She had arrived in New York the evening before, had stayed in the station overnight, and had spent the day looking about for work. She had been discontented at home, quarreling with her parents because they objected to her friendship with a certain girl. She admits now that her father was right in his opinion of this friend, for it was this girl who had taken her into bad company. Twice she had had intercourse after becoming intoxicated at parties. Her parents have no knowledge of these experiences. Her mental age was 14.10, I. Q. 92. She had graduated from public schools and had been a telephone operator for

one and a half years. She has never been nervous, has an even temper, but thinks she has a "mean disposition", for she carries grudges and has revengeful thoughts, though she seldom puts them into execution.

Case 6. Another prostitution case, Martha, a widow, aged twenty-six, from St. Louis, admitted that she solicited. She married at sixteen and has three children. Her husband was killed in an accident three and a half years ago while she was carrying the last child. The $1,000.00 which she obtained from his insurance was used up during her pregnancy and the sickness that followed her confinement. She owned her own home and tried to make ends meet by keeping roomers, but she was a poor business manager. She finally had to mortgage her property, and five months before her arrest she was forced to sell out. She placed the older child in an institution, put the two younger ones out to board, and came to New York to see her sister. She returned home after a few weeks, but soon came back with the plan of opening a rooming house here. When her sister, who is thrifty, refused to lend her the money for that purpose, she left her and went to live at a hotel. After four days she had no money to meet her bills and solicited. She had a mental age of 13, I. Q. 81. She did not appear nervous, but said she had worried herself to death, and complained of feeling nervous since the birth of the last child. On being questioned, she admitted that for the last year and a half she had been intimate with a man who had been a roomer in her home. He had not asked her to marry him, but had given her sums of money and had helped in the care of the children. He had become a petty officer in the navy and his ship was due here when she planned her first trip to New York. At the time of that visit she saw him frequently. Her situation is largely accounted for by this infatuation and her poor judgment. An interview with the sister confirmed all the information that the woman had given.

Case 7. Caroline, aged twenty-one, a Philadelphia girl, is a prostitute case. Her general health had been good and she had no neuropathic traits. She went to high school for three years, leaving at seventeen to go to work. She was employed first in a factory; then was a telephone operator for a year, but returned to factory work, making paper portfolios, because she liked it better. In May 1921, her mother became ill and died. After her mother's death, she was sad, restless, and felt indifferent about working. She stayed at home until the end of July, when she went to Atlantic City and became a "hostess" in a café. It was her duty to dance with men who had no partners. She and her companion say that they were closely observed there, and that nothing improper went on. After working in the café five weeks, the girls came to New York and were arrested the night of their arrival. In Atlantic City they had met a man who told them that he was a "booking agent for chorus girls", and would get them places in a chorus, and they met him there by appointment. He warned them not to enter into conversation with any one on the street, but they had no sooner left him than another man spoke to them and invited them to supper. They ate with him and had gotten in a taxicab with him when another taxi drove up, stopped them, and arrested the girls. Caroline's companion was a bleached blonde, aged nineteen, of border-line intelligence, eager for

show life. While she denied prostitution, she admitted immoral relations and was apparently without conflict about her behavior. Caroline, on the other hand, was pleasing and attractive in appearance, kindly and affectionate in disposition, with no real desire to go on the stage. She came to New York because, since her mother's death, she had not been able to be contented at home. Though her mental age—17.6 years, I. Q. 109—was above the average, she was quite lacking in self-confidence, self-assertion, and ambition. Her older sister who came for her confirmed this impression, saying that Caroline turned over to her her pay envelope unopened, and that she bought her clothes for her. The girl had first had intercourse two years before with a man with whom she was in love. After two months this affair broke up and she soon became intimate with another man. When asked about marriage, she said that she felt that she was too changeable—that she thought she had really cared for the two men, one after the other, but now she looked upon the affairs as infatuations and she believed that her affections were too shallow; she did not trust herself to marry. So we have a girl, well endowed mentally, with some capacity for feeling, yet a weak, drifting individual, who can probably be molded by good influence as easily as by bad.

Constitutional Psychopathic Personality

In the title of this group it will be noted that the modifying terms "inferior" and "defective" are omitted, the emphasis being on the adjective *psychopathic*. These individuals show a better social attitude, a greater emotional capacity. Since they are more sensitive in nature, they are more likely to show symptoms of mental disorders that arise on the basis of conflict of instincts with conventional standards.

Case 8. A colored girl, a high-school student, not a sex offender, was charged with incorrigibility because she ran away from home repeatedly. This overwhelming desire to get away and to be alone is usually associated with the menstrual period. She feels melancholy, "gets a hard feeling toward every one". Formerly she went to the library, where she sat turning the pages of books, but accomplishing little reading. After the librarians learned about her, they questioned her, and she began to drift about the city, often spending the night in the subway. The girl is active in church work and eager to complete her education and follow out her ambition to be a missionary.

Case 9. Bessie, aged eighteen, is a prostitution case. At the age of eight, she had diptheria and was critically ill, and the two following years she had St. Vitus Dance. On account of heart trouble, she was not permitted to walk much and remained in bed a great deal. She was troubled with enuresis until ten years old. Because of a chronic nasal discharge, she has had two operations within the last year. After finishing parochial school, she attended commercial high school for eight months. She was first employed as a telephone operator, but resigned after several months on account of the nasal discharge. Then she tried

working in a department store, but left for the same reason. She was a dancing instructor for a time, but gave that up after two months and returned to the telephone company. She left there because she felt too weak to work, and for the last four months before her arrest she had not been employed. Her attitude about the nasal trouble is distinctly abnormal. She gave up all jobs because she thought she was not wanted, that the nasal discharge was offensive to others. She said that the discharge had a foul odor, that it made her weak and poisoned the air that she breathed. As a matter of fact, no odor at all was noticeable as one talked with her. Her mother is dead and she lived in an orphanage until the age of fifteen, then with a married sister of whom she is very fond. She could not get on with her sister's husband and left her, taking a room in the same house where her father lived. She cooked for him and herself, but she found this too lonely, and with his consent she went to live with a girl friend. This friend had trouble with her aunt, with whom she lived, so the two girls went away and took a furnished room. They had $20.00 between them, but this soon went, and constant moving was necessary since they could not meet the rent. She admitted that they had solicited, but she had avoided intercourse whenever possible. She would go to a restaurant with a man, get a meal, then make some excuse, or she would go to the ladies' room and slip away. At the time of their arrest, the two girls had given up their room, had checked what clothing they had, and had spent the night in the Pennsylvania Station. The next day they solicited two men who happened to be detectives. The girl has an intelligence level above the average—mental age 17.5, I. Q. 108—but as we have seen, she was an invalid child with neuropathic traits. She now feels weak all the time and has headaches. She has been quite despondent and worried a great deal. She was troubled with insomnia, could not get to sleep, and smoked many cigarettes. She maintained that up to six months ago she did not have exact sex information; she had pondered about such matters, but had asked no questions. Last summer after being intoxicated at a Coney Island party, she had sexual relations for the first time, but she had liked the man and had willingly gone with him several times afterwards. She denied that she had had intercourse again except on one occasion when, after soliciting, she had been unsuccessful in avoiding it. As she talked, she cried constantly over her disgrace and the sorrow she had brought to her father. What was back of her pathological attitude about the nasal discharge could not be determined during the interview.

Constitutional Psychopathic Inferiors.

This group is not at all well defined, but in the main one can say that they are egocentric individuals, with difficult personality traits, with symptoms of nervous instability, poor balance, and lax moral standards. They are frequently dishonest and extremely undependable. They are usually active trouble makers, often given to violent outbursts of temper.

Case 10. Ruth, aged seventeen, an incorrigible girl, was brought to the examiner because she had broken her probation. During the last year

she had run away from home five times. This time she was accused by the detectives who found her of consorting with negroes and practicing perversions. She was a rather pretty girl who coöperated well in the examination, giving in detail her version of the difficulties. Her intelligence was average—mental age 15.6, I. Q. 96. Her parents were strict orthodox Jews, and her earlier runaways were due to their uncompromising attitude and her craving for excitement. She was ambitious socially and felt that their home was not nice enough for her friends. She had had about two years in high school and then stayed at home while her mother attended to the shop. She had never been employed, and said she would not care to have an ordinary job, but might like to work in a first-class store and sell lovely things to nice customers. She confessed that she had had immoral relations with a friend two weeks before she left home the first time. She was partly threatened and partly persuaded into the act, but thereafter she was easily aroused and had repeated experiences. She denied the charges which the detective made, but admitted that she had been in colored cabarets. She did not deny that she prostituted when in need of money. This, however, was not without some conflict, for she said, "I know in my heart and soul I am not a prostitute, yet what else am I doing?" It seemed useless to send this girl home, yet there is no institution for Jewish girls. Probation officers and relatives were at a loss to know what to do. At that time it was reported that girls could be observed in the Bellevue Psychopathic ward and be admitted to Bedford Reformatory from there. After being at Bellevue for one month, she was returned to the court with the recommendation that she be committed to Bedford. Since the charge against her was incorrigibility, the judge again permitted her to go home. The hospital record stated that she undermined the morale of the ward, spoke disparagingly of other patients, had outbursts of temper, and became quite threatening in her attitude. It was also stated that she openly boasted of her immoral acts. After she went home, arrangements were made for her to reënter high school, but her teachers had to speak to her about her manner of dress and excessive use of rouge. They also said that she talked to other girls about her sex experiences. She deceived her parents and teachers and within a few weeks she again disappeared.

Case 11. Edith, aged twenty-six, was arrested on a prostitution charge. As a child this woman had many illnesses, though none severe excepting scarlet fever. She was badly spoiled and "extremely nervous". She could not sit still, trembled at the least excitement, was apprehensive and given to worry. She left high school at the end of the first year, because she "had stage on the mind". She went immediately into the chorus of a musical comedy. She was then sixteen and she has been in chorus for ten years, never able to advance because of nervousness. Five years ago she was offered a place in the cast, but had to refuse because of the lack of self-confidence. At present she complains that she cannot sit still, that she is always dissatisfied, never contented to be in one place more than a week at a time. She feels that her brain is working all the time, she cannot relax, feels all knotted up inside, and cannot sleep. She describes herself as headstrong and stubborn, yet says that she gets along well with every one. Her mental age is 16 years, I. Q. 100, which is taken as normal. In regard to her sex life, she was infatuated

with a man at nineteen and had immoral relations; then she was kept for several years by another man. While she denies that she is promiscuous, she pleads guilty to the charge of soliciting in a hotel. Her excuse is that she was out of money. She takes the matter very lightly and is not at all distressed about her situation. When asked about pervert practices, she denied them, then added, "Many crazy women have chased after me. I'll have to try that next."

Constitutional Affective Defective Type

In taking up this last group, one must emphasize again the point that there are no sharp lines of demarcation between the groups. They have this point in common—there are no cases with mental defect. In the normal class were those of better balance, with little nervous instability, and with a minimum of neuropathic traits. They have some capacity for natural affection and normal emotional response. This is shown in their reaction to their arrest. These women, as a rule, felt the shame of a court record. The experience brought them to a realization that they were drifting in a downward direction, and this was a decided point to the good in rating them above the inferiors. The next small group represent those who have a better sort of personality, but they show evidence of distinctly pathological processes in their mental life. One girl, who has been briefly described (Case 8), was subject to states of dissociation; the other (Case 9) was an example of what is known as the chronic invalid or psychoneurotic type. This girl would probably not have solicited had she had a good home, though she would probably still have been an invalid. Her excuse for soliciting was that she was too weak to work, but this "weakness" had its origin in false notions about a chronic nasal discharge. The third group, the psychopathic inferiors, are inferior from many standpoints, stability, adaptability, poor balance emotionally, and inferior standards of conduct. It is somewhat of a residue of cases that do not fit the other groups.

The women of the last group, the constitutional affective defective type, have a minimum of the explosive and impulsive characteristics so common in the psychopathic inferiors. They have little of the nervous instability, and seldom have a history of neurotic traits now or in early life; they are much more placid in nature and not inclined to stir up trouble. Phy-

sically they are inert, and it seems that their only form of self-assertion expresses itself as self-adornment. They are the "dolled-up", artificial type, and must have the latest "craze" in dress. Since they are constitutionally low in energy, they cannot possibly acquire such possessions with their earnings. In fact, most of these girls did not bother about a job at all; they were glad to be "kept". They frankly admitted that they were lazy. Since they have little capacity for real affection, and are usually without any sexual reaction at all, intercourse was a matter of indifference to them. They knew that it was expected and they simply "paid". In the course of the interview, after as much of the personal history as possible had been obtained and the examiner had some knowledge of the girl's family and friends, the girl was asked which person meant most to her—whom she had liked best or to whom she had been most attached. So often one got the answer, "I never really cared for any one", or "I never loved anybody." To sum up, the striking points in these histories are: the lack of natural affection, the lack of energy, and the lack of normal sexual stirrings. To compensate for these deficits, the girl finds her satisfaction in personal adornment, in an artificial, striking, cheap-rich style of dress. One naturally characterizes these individuals as shallow or superficial. On account of the emptiness of their natures, they are deprived of the satisfaction that normal people derive from work, friendships, family relationships, and desire to win approval.

Case 18. Pauline, aged eighteen, was a prostitution case. This girl had been brought to court by her aunt on the charge of incorrigibility in June 1920, and had been given six months' probation. She was seen by the examiner in January 1921. She had left her aunt's home, had taken a furnished room, and had been arrested for soliciting. She had always been strong and well, never nervous in any way, no neurotic traits. Her mental age is 14.5 years, I. Q. 90. In disposition, she is placid and even-tempered. When asked what she considered her worst fault, she said that she was lazy. She hated to get up, "fooled around" until it was too late to go to work; then it was easier to go with men. She had had intercourse at sixteen while intoxicated, but she refused to tell much about this experience. She admitted that she had been living with a man, also that she solicited, and that she had had no regular job for four months. She is several months pregnant. On account of gonorrhea, she was sent to the Kingston Avenue Hospital. In the hospital the women do not wear their own clothes, and most of the girls are hardly to be recognized when they lay off their "make-up",

but this one was "dolled-up", rouged, had her eyebrows plucked and carefully penciled. When told that her appearance was conspicuously different from that of most of the others, she explained that this manner of dress was a "habit".

Case 18. Hannah, aged twenty-six, convicted of prostitution, was an intelligent woman, dressed in good taste, refined in manner. Her mental age was 16.2, I. Q. 101, and she said that she was a college graduate. (A report from the college that she mentioned showed that she had not been enrolled there, but letters received from her mother confirmed her statements regarding her home life.) Her general health had been excellent, and she was in no way nervous or unstable. Her family live in the West and are in good circumstances. She came East to go to school. On account of her ambition to go on the stage, she also attended classes in a "school of oratory". While in the East, she had a love affair and entered into sexual relations, became pregnant, and had a miscarriage. After she finished school, she taught in a high school for one year, but her stage ambitions were pressing, and she satisfied these cravings by becoming a Red Cross entertainer on a voluntary basis. Her parents have always supplied her with some money, but not enough for the pleasures she desires. For a number of months she was a man's mistress in a city in the Middle West. Over a year ago she came to New York hoping to get on the stage, but she made no real effort to attain her ambition. She went home this summer, but returned in a few weeks, taking a room with the girl with whom she was arrested. She denied that she prostituted for money, but said that she must have gayety and entertainment and was willing to pay the price. Intercourse meant nothing to her, and since she had "lost her virtue", what did it matter? She had not thought much about the way she was drifting in life and never worried over moral issues. The desire to go on the stage, she thought, arose from vanity. It was found that she had syphilis, and she was sent to Kingston Avenue Hospital.

Any one familiar with mental disorders is struck by the three characteristics that occur together—namely, the inadequate emotional reaction or lack of affection, the lack of energy, and the lack of natural sexual feeling. These represent exactly the domain of the personality that is disturbed in the affective psychoses, of which manic-depressive insanity is the prototype. It should be made clear that in patients suffering from this mental disorder, it is not at all a question of a *deficit of these feelings,* but a disturbance in the working of these forces. An individual must necessarily have capacity for feeling and affection in order to react to events with such an illness. In the manic-depressive type of disorder there are two phases or pictures, as the name suggests. In a depression, the patient is sad, melancholy, and sees nothing ahead in life but doom and destruction. She sits in one place all day,

quite inert. She will tell you that her mind does not work as it did; she has difficulty in planning. She cannot make and carry out decisions. Moreover, she is aware that her affections have changed; her feelings have lost all their warmth, even her children do not seem like her own, and she is puzzled to know why she does not care for them. This depressed mood, loss of affection and interest, this diminution of mental capacity, are accompanied by a slowing up of all the bodily processes. The patient speaks very slowly in a voice that is hardly audible; she loses all desire for food, and her bowels become sluggish. Normal sexual desire and sexual response are in abeyance.

In the opposite phase of this disorder, there is exhilaration, an extremely happy, even hilarious mood. The patient is not aware of any sickness; in fact, she never felt better. She can think quickly, associations come freely, she is full of schemes, talks constantly, and is in never ceasing activity. This condition frequently reaches the degree of a violent excitement. With the overstimulation psychically and physically, the judgment becomes poor, and the patient may do all sorts of absurd or indiscreet things, especially since there goes with the condition an arousal of sexual cravings with a lack of normal inhibitions. The principal causal or precipitating factors in the affective disorders are emotional shock or strain or a conflict in the instinctive life; whereas, in the women grouped as affective defectives we find an indifference to their past experiences, a lack of conflict or distress. Now we know that there is an hereditary factor in the affective disorders, that they tend to run in certain stocks, just as we know that feebleminded beget feebleminded. This indicates that *affect* (a term referring to the dynamic forces of personality, feelings, affection, and driving emotions) is a fundamental unit in a person's make-up and that the individuals of this group are characterized by their affective defect. Just as there are degrees of mental defect, so there are degrees of affective defect. The comparison of affective defect with intelligence defect is made simply to emphasize its inherent, fundamental nature. Individuals of mediocre or low intelligence may be sensitive, loyal, and affectionate, and they may and sometimes do have affective disorders of the manic-depressive sort.

Summary of All Cases

The discussion of normal and abnormal personalities has been confined to the prostitute cases and incorrigible girls who ranked above the border-line level in the intelligence tests. The examiner has gone over the 300 cases with a view to grouping them according to mental defect, personality deviation, and mental disease. The results are shown in the following table:

Normal type	33
Inferior or psychopathic personality types	139
Border-line intelligence	52
Mental defectives	71
Insane	14
Drug addict	1
	300

This classification on a double basis is far from satisfactory; it is merely an attempt to bring the 300 cases together in one table. It will be noted that the 71 feebleminded are presented together as a group, no attempt being made to study them from the personality standpoint. Any one who has had to do with mental defectives knows that they vary greatly in reactions and behavior and capacity for affection, but since they do not have the intelligence to analyze and describe their traits, one would not be justified in judging them by a brief examination, but would need to observe them in various situations. In the border-line-intelligence group, one sees a wide range of personalities. Those resembling the abnormal types are grouped with them, while 52 are allowed to stand, for with them low mental capacity, rather than abnormal or difficult traits, seemed to be the important factor leading to the arrest.

The terms constitutional inferior, constitutional psychopathic personality, and constitutional psychopathic inferior are not sharply defined and are often interchanged indiscriminately. Some accurate discrimination in the use of these personality terms will come out in the present intense interest in the study of personality traits and types of reaction. Until recent years the study of mental disorders was confined to observations on psychotic patients, so ill that they required hospital care. Pathological behavior that did not fall within

the range of the well-known disease pictures did not receive much attention. With the present trend of mental hygiene, it is the aim of the psychiatrist to understand each individual—his ambitions, capacities, and handicaps—and to try to find out just how his experiences have affected him and how his reactions to the events of his life have modified his attitude toward himself and toward society. With the spreading of the interest of the physician from the severe to the milder disorders, there has grown up a science of medical psychology, but for this, as for other sciences, there is a big field to be explored. Individuals vary so greatly in so many kinds of traits, abilities, defects, and modes of reaction, that it is futile to search for the "normal". What one can best do in the present state of our knowledge is to use descriptive terms and search for types.

In making reports to the judges, the examiner was extremely wary of making specific recommendations except for the insane and the low-grade feebleminded. The report consisted in a statement of the intelligence level, remarks concerning habits of work, nervous stability, emotional reactions, together with any information obtained that threw light on the reasons, motives, and circumstances that led the girl into a situation that made an arrest possible. The examiner had had no experience with correctional institutions or with remedial measures of that nature. As a result of this study of the 300 women, the opinion has grown more firm and definite that the problem of delinquency, antisocial conduct, and abnormal behavior is a very complex one that can be satisfactorily met only when judges, probation officers, criminologists, officers of correctional institutions, psychiatrists, and social workers pool their knowledge and experience. In fact, the problem is a community problem. The court is a clearing house for all sorts and conditions of people who are obviously making a failure in life. It should be a scientific, social laboratory of first importance. Of course, the problem of prostitution is a problem bigger than the court and will not be discussed, but to make the court work more effective there are many needs. A house of detention, where women can be held until investigations are made, is absolutely essential. Longer time than the customary forty-eight hours is needed, especially since within

this brief period it may not be possible to get in touch with any relative or friend of the woman. A good many of these offenders are not residents of New York City, and two days hardly allow time for an exchange of telegrams; one must remember, too, that often the information first obtained is false.

The five women probation officers are tremendously overburdened. Each day brings new cases for investigations that have to be made promptly and too hurriedly. These officers give an evening each week to seeing the girls who are on probation who are required to report to them, but time does not exist for active, constructive work with each individual beyond what can be obtained in these brief contacts. The judges come to the court two evenings a month to hold personal conferences with the women on probation and to discharge those who have finished their probationary period. The present court rooms are entirely inadequate. The desks of the five probation officers are crowded together in one small room, and opportunity for private conversation is entirely lacking. One is filled with wonder that the probation officers faithfully carry on their work in spite of the confusion that exists. It is not possible under present conditions to obtain a thorough investigation, especially of work, school, and birth records, in the allotted time. Important factors are constantly coming to light after the disposition of the case has been made. For instance, two girls in this series are under sixteen years of age. One of these, a girl of fourteen, who said she was twenty, refused to give information that would lead to her identity. In size and appearance she passed without question for an adult. She had normal intelligence. She talked freely of her experience, admitted that she prostituted, and was thoroughly familiar with the language and customs of women of the street. After she had been sentenced to the workhouse, a telegram that had been sent to the chief of police in a certain city which she had mentioned led to the finding of her mother, who was living here in New York. Besides the precocious physical and sexual development, there were other signs of disturbance of function in the glands of internal secretion.

The report as a whole shows that the court offers many important problems to the psychiatrist. The examinations should enable the judge to sort out immediately the low-grade

mental defectives and the insane. The reports should give the judge and the probation officers information concerning the personalities of the women that will enable them to handle the individuals with more insight. The results of the work should ultimately aid in the solution of correctional problems. The psychiatrist should be of assistance in following the probation cases with the probation officer. By getting in touch with the women in a medical way there is greater opportunity to help them with their personal problems. While it was the purpose in undertaking this study to limit the examinations to the incorrigible girls and first offenders in prostitution, the requests for examination of older prostitutes and the cases referred from other courts indicate that there is a great deal of mental defect and mental disease among the older prostitutes and the women arrested as vagrants with no homes.

In closing, the writer wishes to say that she is especially indebted to Miss Maude E. Miner, the executive secretary of the New York Probation and Protective Association. It was her interest and energy that created this opportunity for a psychiatrist to be present and work in the Women's Court. Dr. Anne T. Bingham, psychiatrist to the organization, not only acted as substitute at the court when the examiner could not be present, but also gave freely of her time to the discussion of cases. Her long experience with delinquent girls made her an exceedingly valuable and stimulating advisor. Miss Elizabeth Greene, the organization's psychologist, gave most of the Terman intelligence tests, and contributed valuable observations on the girls' reactions and behavior. The probation officers at the court showed an active interest and were uniformly coöperative. Miss Alice Smith was especially helpful. Her resourcefulness in meeting the many practical difficulties encountered made it possible to conduct the examinations.

A CONTRIBUTION TO THE MENTAL PATHOLOGY OF RACES IN THE UNITED STATES*

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TO those who believe with Kraepelin that the disposition of a people finds expression in its mental diseases, it would seem that investigations of the mental pathology of peoples and races might lead to some information as to the general characteristics of the peoples concerned. The character and degree of intelligence, emotional stability, morale, and tendencies to criminalism and to inebriety, might be revealed by these measures. Such information might well be more definite than indicated by the actual number of cases found, as for each case pronounced enough to be called a disease there would be many border-line ones of the same category showing the same general trends. An excessive distribution in any community of any particular type of disease might well indicate the general mental level and trend of that community.

Obvious difficulties stand in the way of investigations of this kind. Intensive surveys are necessarily restricted to small groups, and are limited in their general application. General statistics have never been compiled in a manner to throw much light on the subject. The neuropsychiatric statistics of the army, however, afford an opportunity to analyze a large group of all kinds of neuropsychiatric defects and disorders which existed in the representative manhood of the country from 1917 to 1919. It is the purpose of this paper to set forth the results of the analysis of these cases as far as they concern certain foreign-born and native-born races.[1]

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1 The classification of races made use of is taken from the *Dictionary of Races*, prepared under the direction of the Department of Immigration and published in 1910.

From them it appears that, with the exception of epilepsy, certain communities and certain races in the United States display wide variations in the distribution of one or another form of nervous or mental disorders found among them. For example, according to the statistics, the negro exhibits a tendency toward mental defect and away from every other neuropsychiatric condition, while the native-born Scot shows a tendency away from mental defect and toward alcoholism and certain other neuropsychiatric conditions. The widest variations occur in reference to mental defect and inebriety, and the chief value of this study concerns the variations found in respect to these two conditions.

Some races and some communities adhere closely to the median or average. For example, the English show little tendency to vary from the established average. In view of the place the English hold in the world, there is nothing in the present statistics to justify the denial that the middle course, as far as the distribution of nervous and mental disease is concerned, may be the characteristic of the people that attains the most power in the end.

The social value of such information as the statistics yield would, of course, be enhanced by comparison with additional information concerning the circumstances of residence of these races in this country. To draw any final deductions, it would be necessary to know the circumstances of immigration, the causes of emigration, class of immigrants, localities settled in here, and nature of occupations followed.

For example, the statistics indicate that the Italians and Mexicans in the United States are at a low level of intelligence and unable to compete with, let us say, the Scotch or the Irish. But they give no information as to whether these people represent an average of Italians and Mexicans living at home or are merely representatives of inferior groups of Italians and Mexicans who, for some reason or other, have come here.

In comparing the native born with the foreign born, particularly, it would be valuable to know about the circumstances of immigration. The number of foreign-born peoples separately classified is limited, by necessity, to four races: Italian, Scandinavian, Irish, and German. As between them and the

native born of the same race, certain definite variations in the distribution of neuropsychiatric defects are noticeable. For example, practically all native born were found to be more addicted to drugs than the foreign born. Residence in this country seems to foster a drug inebriety or to convert alcoholic inebriety into drug inebriety. Similarly, there appears to be a decrease in the number of cases of insanity among foreigners after residence in this country. Final explanation of these facts, however, must await a fuller knowledge of the circumstances under which a particular group of foreigners came to this country.

Method

The present statistics record only those cases which were identified at recruiting-depot posts and at camps—namely, at the military points of enrollment. They record diagnoses or identifications, irrespective of the military disposition made of the cases. They do not take into account the men rejected by local boards. Thus they cannot determine the percentage of neuropsychiatric cases to the total number of men examined. Information of this character, as far as draftees are concerned, may be obtained in the reports of the provost marshal-general, and in *Defects Found in Drafted Men.*[1] The method used here is that of distribution averages solely. It begins with 69,394 fully classified cases found among volunteers and draftees. (See chart, page 375.) This total of cases was divided into nine distinct clinical groups, and the percentages assigned to each group indicate how that group stood in relation to the total of neuropsychiatric cases found. Thus of all neuropsychiatric cases found in the home forces, black and white, 31.5 per cent were cases of mental deficiency. This percentage represents the distribution average. As such differences existed between white men and negroes, when the distribution average of the United States was determined, it was determined separately for white and colored persons. By this method the average for mental defect in the United States was estimated from the distribution of mental defect among white persons and was found to be 29.2 per cent. A similar

1 *Defects Found in Drafted Men.* By A. G. Love and C. B. Davenport. Washington: Government Printing Office, 1919.

procedure was followed to determine the variations in the distribution of the various disease types found among the inhabitants of the different states and, as concerns the present article especially, among the members of certain foreign-born and native-born races. The total number of neuropsychiatric conditions found among a people—the Scotch, for example—was ascertained, and the percentage belonging to each clinical group was determined for the Scotch in the same way that it had been determined for the people of the United States as a whole. There was thus furnished a means of comparison between the distribution of each clinical group throughout the United States and the races that were classified. Startling variations were disclosed. This paper was written in the belief that these variations have something to offer toward the understanding of the characteristics of the different peoples concerned.

In interpreting the results, two cautions should be kept in mind: First, as all percentages are based on the total number of neuropsychiatric cases from each race, it is evident that when an excessive percentage is taken up by a single condition, the percentages of the other eight groups must be low—that is, a high rate in one group tends to lower the rate in all other groups.

It also should be noted that in reporting cases the examiners had to choose at times between two or more neuropsychiatric disorders. It is probable that constitutional defects were preferred to alcoholism or drug addiction. But this overlapping is not believed to have affected the rates to any great degree.

Clinical Classification

The chart (page 375) shows the nine clinical groups into which the whole material was divided. It is made up of all cases in which the information was sufficiently detailed to be classifiable, and the figures are only a little under the total number of diagnoses made.

Mental Deficiency.—No idiots reached the military posts, and so this group is made up of imbeciles, morons, those whose disease was on the border lines, and a small number in whom the degree of defect was not determined. About 86 per cent

of all those whose cases were identified were discharged from the service, and as the standard for discharge was fixed approximately at a mental age of eight years, it is assumed that the bulk of the cases were at the eight-year-old level.

Psychoneuroses.—This group is composed of neurasthenia, hysteria, psychasthenia, stammering, enuresis, anxiety neurosis, traumatic cases, and a few scattering and undiagnosed cases.

Psychoses.—In this group are included dementia praecox, manic-depressive insanity, general paresis, and other psychoses associated with syphilis, mental deficiency, and epilepsy.

Nervous Diseases and Injuries.—In this class are grouped the injuries of the nervous system, its organic diseases, and such conditions as tremors, sciatica, tics, etc. Syphilis of the central nervous system was held responsible for 40 per cent of these cases, and consequently a high distribution rate of this group in a people gives some indication of the frequency of syphilis in that people. If to them are added the psychoses due to syphilis (general paresis) and psychoses with cerebral syphilis from the preceding group, the percentage of late nervous syphilis to the total of 69,394 cases would be approximately 3 per cent.

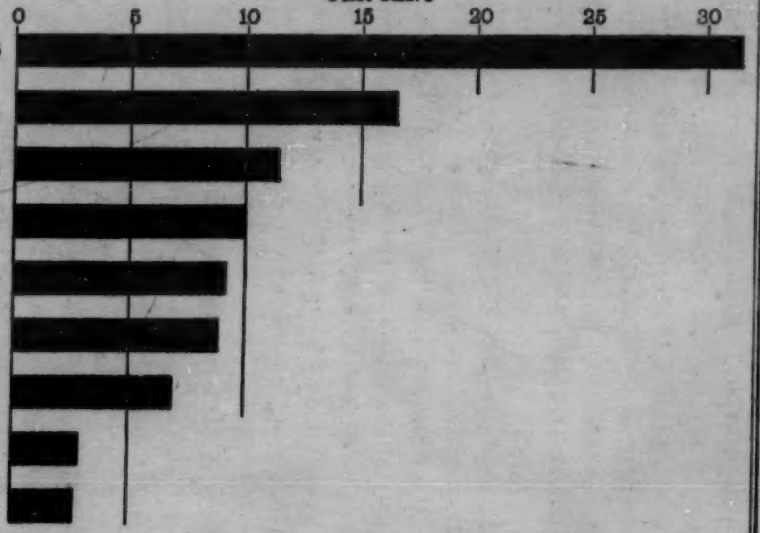
Epilepsy.—This includes both grand and petit mal attacks.

Constitutional Psychopathic States.—This group contains persons socially undependable as determined from personal examination and from past records, classified into those with inadequate personality, emotional instability, paranoid personality, criminalism, sexual psychopathy, and a few other scattering forms. These persons are not feebleminded; on the contrary, they often have active intelligence, thus belonging to the groups of developed intelligence rather than to the mental-deficiency group.

Endocrinopathies.—This group is much larger over the country as a whole than appears from the present statistics because, under the names "effort syndrome", "cardio-vascular" disturbances, etc., many cases fell exclusively to the cardio-vascular examiners. The cases given here include those in which were symptoms of great nervousness, combined with definite lesions referable to the endocrine glands. In 93.7 per cent of the cases the gland at fault was the thyroid.

DISTRIBUTION OF ARMY NEUROPSYCHIATRIC CASES

DIAGNOSES	NUMBER	PER CENT
MENTAL DEFICIENCY	21,856	31.5
PSYCHONEUROSES	11,443	16.5
PSYCHOSES	7,910	11.4
NERVOUS DISEASES AND INJURIES	6,916	10.0
EPILEPSY	6,368	9.2
CONSTITUTIONAL PSYCHOPATHIC STATES	6,196	8.9
ENDOCRINOPATHIES	4,805	6.9
DRUG ADDICTION	2,020	2.9
ALCOHOLISM	1,858	2.7
TOTAL	69,394	100.0



Alcoholism and Drug Addiction.—Alcoholism in these statistics implies a chronic intoxication so profound that the person was, for the most part, beyond reconstruction for military purposes. Drug addiction, while allied to alcoholism as a form of inebriety, is subject to wide variation due to local conditions. It will be observed that the number of drug addicts and of alcoholics is practically the same. It should not be inferred, however, that these two disorders are of equal social importance, for that is far from true. The majority of intemperate men were accepted for service and made good. No medical record was kept of their habits. Records were kept only of the more or less permanently incapacitated alcoholic men. Quite the contrary was true of the drug addicts. They have always been looked on with disfavor by military authorities, and few were retained.

Mental Defect the Pivotal Point

Mental defect, being the most widely distributed condition and the one most directly concerned with the question of general intelligence, becomes naturally the pivotal point of the present discussion. It is assumed to be a distinct clinical entity, classifiable and distinct from insanity or any other of the various neuropsychiatric conditions.

It is the result of a failure of development of the mentality up to a capacity which, as we are dealing only with adults, we may call adult capacity. The normal of adult capacity has been roughly established by psychologic tests among civilized people. It is still unsettled whether or not this standard would be the same for primitive races as for cultured ones—that is, whether or not an average child of a savage, if from infancy it were given the same advantages as, let us say, the average French or English child, would develop into an adult with the average intelligence of a Frenchman or an Englishman. From the statistics which relate to two so-called primitive races—the African and the American Indian—it appears that the primitive could not under any present circumstances attain the average intelligence of cultured races. This appears to be so, not because there is any detailed information as to the potentiality of the primitive mind, but

because mental deficiency is so profusely distributed among Africans and American Indians that their average intelligence must be inferior to that of average European intelligence.

At this point arises a question, and one that cannot be answered from the data on hand: What does excessive mental defect in a race mean? Is it a biologic condition marking the race as being in an early phase of development and establishing a level of intelligence more or less normal for the particular phase of evolutionary development in which the race finds itself, or does it mean that the race has been brought back to a regressive phase through the unrestricted interbreeding of mental defectives? That Caucasian strains can be reduced to low levels of intelligence we know from observation of communities in which the continual interbreeding of mental defectives has brought about that result. Is it possible that in a race we call primitive, like the negro race, a similar thing has occurred, so that the backwardness is the result of some racial setback?

The distribution percentage of mental defect is taken as an index of general intelligence, because when this distribution is excessive, the average intelligence can hardly fail to be lowered. It is lowered not only by the actual mental defectives, but by the number of dull people which the existence of mental defect implies, for it is estimated that for every case of mental defect of the eight-year-old mentality standard, there are at least ten cases of backward or retarded mentality.

An example will make this plain: Vermont[1] showed among its draftees 30.90 mental defectives for every 1,000 men examined. What does this indicate about that community? As mental defect shows no great predilection for either sex, it means that had females been included in the draft restriction, the rate of 30.90 would have been maintained for both sexes in the given age period. As mental defect shows no special predilection for the age period from twenty to thirty, it means that this rate would maintain for the whole population at all ages. It would, therefore, apparently be safe to assume that there are at least thirty defectives per thousand in Vermont of the eight-year-old mentality type, and 300 per 1,000 of

[1] See note, page 372.

TABLE 1. DISTRIBUTION RATES IN NINETEEN STATES IN WHICH THE UNITED STATES MENTAL DEFICIENCY RATE OF 29.2 PER CENT WAS EXCEEDED

STATE	PERCENTAGE OF TOTAL CASES FROM EACH STATE								
	Mental Deficiency	Psychoneuroses	Psychoses	Neurologic Conditions	Constitutional Psychopathic States	Epilepsy	Endocrine Disturbances	Alcoholism	Drug Addiction
United States average..	29.2	17.0	12.1	10.0	9.7	8.6	7.4	3.0	3.0
Alabama	36.0	20.1	11.8	9.9	7.3	9.3	4.0	0.5	1.2
Arkansas	43.7	21.0	9.1	7.2	6.4	8.4	1.4	0.2	2.6
Florida	31.1	18.4	14.5	9.2	8.8	11.2	3.5	0.4	2.9
Georgia	33.3	13.0	13.4	11.5	11.8	7.9	6.1	1.7	3.5
Kentucky	41.1	14.0	6.9	11.8	9.4	8.8	4.2	2.6	1.3
Maine	51.5	13.0	7.7	5.4	8.9	9.2	0.5	2.6	1.3
Maryland	44.9	13.3	10.4	7.6	10.7	4.5	4.4	2.5	1.6
Mississippi	35.4	23.2	9.8	8.3	6.7	10.9	2.1	0.6	3.1
Missouri	33.8	15.9	8.5	11.4	9.4	6.3	8.5	3.3	3.0
New Mexico	61.2	7.0	5.5	7.3	6.1	8.8	3.5	0.6	0.3
North Carolina	46.7	17.7	8.0	6.6	3.9	9.6	6.1	0.6	0.7
North Dakota	38.5	14.1	12.6	9.2	10.3	8.0	3.8	3.1	0.4
Oklahoma	33.3	15.6	11.8	12.7	6.7	6.7	4.0	1.9	7.4
South Carolina	43.4	19.6	7.0	8.2	4.1	8.9	6.1	1.8	1.9
South Dakota	33.1	14.4	10.5	12.8	3.9	6.6	16.1	2.3	0.3
Tennessee	43.0	14.3	9.6	11.9	3.8	8.0	5.1	0.8	3.5
Vermont	33.6	16.3	13.3	10.6	10.6	8.8	3.5	2.7	...
Virginia	45.5	12.0	9.2	7.0	7.4	5.8	10.9	1.0	1.5
West Virginia	38.6	12.6	8.2	9.1	7.8	6.3	15.7	0.7	1.1

TABLE 2. DISTRIBUTION RATES IN FIVE RACES IN WHICH THE UNITED STATES MENTAL DEFICIENCY RATE OF 29.2 PER CENT WAS EXCEEDED

	Number Classified	PERCENTAGE OF TOTAL OF EACH RACE								
		Mental Deficiency	Psychoneuroses	Psychoses	Neurologic Conditions	Constitutional Psychopathic States	Epilepsy	Endocrine Disturbances	Alcoholism	Drug Addiction
United States average.....	...	29.2	17.0	12.1	10.0	9.7	8.6	7.4	3.0	3.0
African	8,401	48.3	13.1	6.6	9.5	3.0	13.3	3.6	0.3	2.3
American Indian	124	62.9	4.0	4.0	4.0	8.9	7.3	2.4	2.4	3.2
Italian	2,452	32.7	18.1	9.7	7.8	9.3	12.8	3.8	0.4	5.3
Mexican	384	66.9	4.2	4.7	5.7	3.9	11.7	2.3	...	0.5
Slavonic	2,474	37.0	15.3	14.5	7.3	10.0	6.6	5.7	2.5	1.2

backward or retarded persons—persons of distinctly inferior intelligence. In other words, nearly one-third of the whole population of that state is of a type to require some supervision and special educational facilities, and even then they cannot attain the average intelligence of cultured races.

In addition to the lowering of the general intelligence brought about by an overproduction of mental defectives plus the dullards who are always found with them, the outlook for the general intelligence is further impaired by the reduction in the chance of the appearance of persons of superior intelligence with the qualities of leaders.

When countries and especially when races are compared, the significance of a high ratio of distinctly inferior persons in a community becomes apparent. For example, the American Indian presents among his nervous and mental disorders a mental-deficiency-distribution rate of more than double, and the African a rate a little less than double, that of the distribution rate among white persons over the whole United States. This in itself is enough to explain the inability of the two races to compete with the average American. The Mexicans living in the United States present an even higher distribution rate for mental defect (66.9 per cent), but concerning the Mexicans in general—in fact, concerning all races that may have immigrated here within recent years—we can draw no such general conclusions as we can about the indigenous Indian and negro races. Concerning the foreign races that present a high distribution rate for mental defect, such as the Slavs (37 per cent) and the Italians (32.7 per cent), it can only be said that the ones living here now are distinctly below the average United States intelligence. It would be impossible to infer that these races at home present the same degree of mental inferiority; it may be that these countries sent us a high proportion of defectives and that these have intermarried.

Throughout the present material, mental deficiency shows significant correlations with the other neuropsychiatric conditions, and these correlations throw some light on the extent and quality of the intelligence of the people concerned.

As concerns psychoses or mental disorders, it might be assumed that these would be less likely to occur when there was a high rate for mental deficiency. With the exception of the toxic psychoses, the existence of a mental disease implies a developed intelligence, a kind of intelligence that would possess imagination, ideas, a certain quickness in mental processes. As is well known, distinct types of psychoses are

practically unknown in childhood, the period before the intelligence is fully developed. The hypothesis that mental disease implies a developed intelligence and so would be less frequent among people in whom the intelligence is underdeveloped is borne out by the accompanying tables. Nineteen states exceeded the United States mental-deficiency rate of 29.2 per cent, and showed among themselves an average of mental defect of 40.4 per cent. (See Table 1.) But the insanity rate was below the United States rate in these nineteen states, being particularly depressed in the states with high rates for mental defect: Arkansas, Kentucky, Maine, New Mexico, North Carolina, Tennessee, and Virginia. The same correlation holds true for the five races that exceed the United States rate of 29.2 per cent for mental defect (with the exception of the Slavonic)—namely, the Africans, American Indians, Italians, and Mexicans. (See Table 2.)

The converse of this correlation between mental defect and insanity appears in twenty-four states (Table 3) which showed an over-average insanity distribution rate. Of these, North Dakota alone had a high mental-deficiency rate. The same relation holds true for eight of the fifteen classified native-born races which show an excess distribution rate of insanity (Table 6), with the exception of the Slavs. The distribution average of these nine races was 12.3 per cent for psychoses and 21.7 per cent for mental deficiency. An isolated example of the variations between mental deficiency and insanity is shown in the case of Florida. In that state the over-average mental-deficiency rate concerns the white people only—among Florida negroes it was 11.5 per cent, or 17.7 per cent below the United States rate for white people. But the Florida negroes show an insanity rate of 13.8 per cent, which exceeds the United States distribution for insanity in negroes by 7.3 per cent.

Between mental deficiency and alcoholism there seems to exist a very definite antagonism in that the two conditions do not exist in greatest abundance in the same communities and among the same kind of people. When the rate for one rises, the rate for the other falls. Of the nineteen states (Table 1) with an excess of mental deficiency, not one has an excess distribution of alcoholism, and in these nineteen states

TABLE 3. DISTRIBUTION RATES IN TWENTY-FOUR STATES IN WHICH THE UNITED STATES RATE FOR PSYCHOSES OF 12.1 PER CENT WAS EXCEEDED (WHITES)

STATE	PERCENTAGE OF TOTAL CASES FROM EACH STATE								
	Psychoses	Mental Deficiency	Psychoneuroses	Neurologic Conditions	Constitutional Psychopathic States	Epilepsy	Endocrine Disturbances	Alcoholism	Drug Addiction
United States average	12.1	29.2	17.0	10.0	9.7	8.6	7.4	3.0	3.0
Arizona	16.7	15.0	12.5	18.3	11.7	10.9	6.7	4.2	4.2
California	17.4	22.0	16.7	12.2	12.7	7.7	2.7	5.3	3.3
Colorado	14.5	24.8	18.2	10.7	9.5	11.8	6.4	2.1	2.1
Connecticut	15.9	26.7	17.8	7.7	10.3	10.6	3.1	4.9	2.9
Florida	14.5	31.1	13.4	9.2	8.8	11.2	3.5	0.4	2.9
Georgia	13.4	33.3	13.0	11.5	11.8	7.9	6.1	0.7	2.5
Idaho	25.5	26.7	10.3	8.5	6.7	7.9	14.6	...	...
Illinois	13.8	19.9	20.6	10.7	9.1	8.3	9.8	6.2	1.5
Iowa	16.4	25.3	17.8	9.9	9.3	8.4	8.2	2.1	2.6
Massachusetts	14.4	25.7	18.1	6.9	12.2	10.4	1.7	7.9	2.7
Michigan	13.5	29.2	12.0	10.9	11.6	8.6	11.2	2.3	1.1
Minnesota	14.0	22.2	19.5	10.9	7.1	7.8	12.0	4.3	2.2
Montana	20.8	16.7	16.0	11.2	8.9	11.9	7.8	3.0	3.7
Nebraska	15.5	25.1	14.7	12.9	9.4	7.6	10.7	1.6	2.6
Nevada	18.3	18.3	11.7	18.3	6.7	8.3	1.7	15.0	1.7
New Jersey	13.4	27.6	16.6	6.8	11.2	12.6	5.7	3.2	3.0
North Dakota	12.6	38.5	14.1	9.2	10.3	8.0	3.8	3.1	0.4
Oregon	19.7	18.1	19.1	8.9	16.4	9.5	5.3	0.3	2.6
Texas	17.6	25.5	14.8	12.3	8.8	13.4	2.3	1.1	4.1
Utah	18.5	20.5	19.2	6.0	12.6	7.9	4.0	3.3	7.9
Vermont	13.3	33.6	16.8	10.6	10.6	8.8	3.5	2.7	...
Washington	17.7	28.1	14.0	8.2	9.5	7.5	9.3	0.9	6.8
Wisconsin	12.6	27.0	19.2	11.6	6.2	6.8	12.6	3.2	0.7
District of Columbia	19.9	16.1	23.6	14.3	8.7	6.2	6.2	2.5	2.5

the average for alcoholism is 1.6 per cent as compared with 3.0 per cent, the United States average. Conversely, seventeen states exceeded the United States average for alcoholism. A similar antagonism is observed in the various races.

None of the five races (Table 2) that exceed the United States rate for mental deficiency attains the United States alcoholic rate of 3.0 per cent. Conversely, none of the native-born races—the Hebrew, Irish, Scotch, Greek, and Spanish—that exceed the United States alcohol rate attains the United States mental-deficiency rate of 29.2. Similar conditions prevail in the foreign-born races classified.

In the states in which the distribution of mental deficiency is over average, there is practically no change in the rate for epilepsy; in the races a slight increase in the rate for epilepsy occurs. As concerns the psychoneuroses, states and races with plus mental deficiency show a slight decrease. With

some exceptions, constitutionally psychopathic states tended to be below the United States average in both the states and the races that showed an excess of mental deficiency. It would, therefore, seem that an excess of mental deficiency in a people assures an amount of alcoholism, insanity, and psychopathic states below the average, and, conversely, that when these conditions are in excess, mental deficiency recedes.

The foregoing variations apply to the fifteen classified races in the United States as shown in Table 6. Table 4 shows four of them, divided, as was possible, into native born and foreign born.

TABLE 4. DISTRIBUTION RATES OF NEUROPSYCHIATRIC CONDITIONS AMONG FOUR DIFFERENT RACES, WITH COMPARISONS BETWEEN THE NATIVE BORN AND THE FOREIGN BORN

RACE	PERCENTAGE OF TOTAL OF EACH RACIAL GROUP									
	Number Classified	Mental Deficiency	Psychoneuroses	Psychoses	Neurologic Conditions	Constitutional Psychopathic States	Epilepsy	Endocrine Disturbances	Alcoholism	Drug Addiction
United States average	...	29.2	17.0	12.1	10.0	9.7	8.6	7.4	3.0	3.0
Italian:										
Native born	413	23.9	13.6	11.6	6.5	10.9	2.2	1.0	1.2	19.1
Foreign born	2,039	32.5	19.0	9.3	8.0	9.0	15.0	4.4	0.2	2.6
Scandinavian:										
Native born	300	26.7	17.3	15.4	9.1	8.3	6.6	11.0	2.3	2.1
Foreign born	366	15.8	16.9	21.9	12.6	8.5	7.1	9.3	6.6	1.4
Irish:										
Native born	4,088	21.6	14.7	10.9	11.6	11.6	8.2	6.6	9.4	5.4
Foreign born	394	15.0	15.7	20.1	10.9	6.6	7.9	4.8	18.0	1.0
German:										
Native born	4,164	28.1	17.6	12.3	9.6	10.1	7.3	11.0	2.4	1.6
Foreign born	187	25.7	15.5	21.4	10.7	7.0	8.6	7.5	2.1	1.6

MENTAL CONDITION OF VARIOUS RACES IN THE UNITED STATES

African Race.—(Number classified, 8,401.) The most striking characteristic of the negro is the wide distribution of mental defect (48.3 per cent) and the low distribution of alcoholism. In negroes the mental-deficiency rate exceeded the United States rate for white people by 19.1. The Southern states are high in mental defect, but the negro cannot be held entirely responsible for this as in many Southern states the

mental defect for white people exceeds that for negroes, as shown in Table 5.[1]

It will be observed that in these Southern states the average mental-deficiency rate for the white population is considerably higher than the United States average for white people—29.2 per cent—and that the average rate for the negro is considerably below the United States average for the negro—48.3 per cent. In Florida, Georgia, Kentucky, North and South Carolina, and West Virginia there are proportionately more white than colored mental defectives.

TABLE 5.—MENTAL DEFICIENCY DISTRIBUTION RATES FOR WHITE AND FOR BLACK POPULATION IN TWELVE SOUTHERN STATES

	Negroes	Whites
United States average	48.3	29.2
Alabama	66.4	36.0
Florida	11.5	31.1
Georgia	31.7	33.3
Kentucky	38.5	41.1
Louisiana	48.3	28.7
Mississippi	44.6	35.4
North Carolina	40.8	46.7
South Carolina	40.0	43.4
Tennessee	71.8	43.0
Texas	33.4	25.5
Virginia	48.6	45.5
West Virginia	37.5	38.6

Some students seem to think that the backward condition of the negro is the result of his environmental conditions—that if he were given opportunity he could approximate the Caucasian standard of mentality. The present statistics do not bear out such an opinion.[2]

It is true that in certain Northern states the mental-defici-

[1] No cases of mental defect among negroes, or too few to classify, were found in California, North Dakota, South Dakota, Oregon, Utah, Vermont, Washington, and Wyoming. This simply means a small negro population, as these states together gave a total of forty-five psychiatric cases among the negroes.

[2] According to Trabue, intelligence rating taken of drafted negroes from Louisiana and Mississippi, and of white men from Illinois, Wisconsin, and Minnesota, showed that only 0.2 per cent of the negroes from Louisiana and 0.5 per cent of the negroes from Mississippi were graded as superior, while 10.7 per cent of the white men had this standing. At the other extreme, only 7.4 per cent of the white men had a grade of inferior or very inferior, while 52.9 per cent of the Mississippi negroes, and 63.3 per cent of the Louisiana negroes, had this low grade.

ency rate for negroes is much lower than in the South—indeed, in New Jersey it is lower for negroes (21 per cent) than for white people (27.5 per cent). The apprentice system for slaves prevailed in New Jersey until 1863. This system provided supervision and care and may help to explain the present superior quality of negroes in New Jersey. Also, one must bear in mind that mental defect is a social weed, tending to spread. One must also bear in mind the important factor of migration. The brighter and more enterprising members of rural communities have for years been pushing out for the large cities, leaving the dullards and defectives on the plantations and farms. It seems, therefore, possible that the higher mentality of Northern negroes is not the result of environmental conditions, but is due to the fact that they came of better stock in the first place, the Northern negro population consisting of slaves who had had wit enough to escape or servants selected with greater care—that the low mentality of the Southern negroes is due to their staying together and interbreeding.

In contrast to the high distribution of mental deficiency among the neuropsychiatric conditions of negroes, alcoholism among them practically did not exist. There were only twenty-nine cases in all. This absence of the disastrous effects of intemperance contradicts the current belief that the ravages that result from the abuse of alcohol are particularly severe among primitive races. Data relative to the use of alcohol show that 13 per cent of the white and 10 per cent of the colored neuropsychiatric cases had a record of intemperance. It would seem, therefore, that the negro can be practically as intemperate as the white man without paying the same penalty for it. On the other hand, he is much more susceptible to venereal diseases; 57.8 per cent of all negroes gave a history of venereal infections of some sort, while only 22.3 per cent of white people gave such a history. In view of this great disparity, and since the white people actually drank more than the negroes, it would seem that some modification would have to be made in our views of the prime importance of alcohol as a factor in the spread of venereal diseases.

A similar, though less marked, resistance to the involvement of the central nervous system by syphilis is shown by

the negro. Among neuropsychiatric cases the history of preceding syphilis was more than three times as frequent in negroes as in white persons, but the involvement of the central nervous system by that disease was about equal in the two classes.

TABLE 6. DISTRIBUTION RATES OF NEUROPSYCHIATRIC CASES AMONG FIFTEEN CLASSIFIED RACES

Racial groups	Number Classified	PERCENTAGE OF TOTAL OF EACH RACE: Mental Deficiency	Psychoneuroses	Psychoses	Neurologic Conditions	Constitutional Psychopathic States	Epilepsy	Endocrine Disturbances	Alcoholism	Drug Addiction
		7	1	3	8	2	6	9	4	5
United States average	...	29.3	17.0	12.1	10.0	9.7	8.6	7.4	3.0	2.8
African	8,401	48.3	13.1	6.6	9.5	3.0	13.3	3.6	0.3	2.3
American Indian	124	62.9	4.9	4.0	4.0	8.9	7.3	2.4	2.4	3.2
Dutch	328	26.2	14.9	13.1	11.6	10.1	10.4	10.4	1.8	1.5
English	9,092	29.2	16.5	11.8	10.0	10.7	8.9	8.3	2.2	1.9
French	941	20.1	18.5	10.1	10.8	8.0	10.8	5.8	4.1	2.7
German	4,351	28.0	17.5	12.7	9.6	9.9	7.4	10.9	2.4	1.6
Greek	291	23.8	24.9	13.9	8.9	8.2	13.5	5.3	1.1	0.4
Hebrew	1,314	17.2	25.2	14.9	7.5	15.4	7.1	5.6	0.5	3.7
Irish	4,462	21.0	14.8	11.7	11.6	11.1	8.2	6.4	10.1	3.0
Italian	2,452	32.7	18.1	9.7	7.8	9.3	12.3	3.8	0.4	5.3
Mexican	384	66.9	4.2	4.7	5.7	3.9	11.7	2.3	...	0.5
Mixed	23,604	27.5	18.4	12.2	10.2	9.9	8.7	7.2	2.3	3.7
Scandinavian	1,256	23.6	17.5	17.3	10.1	8.4	6.8	10.5	3.9	1.9
Scotch	579	12.4	18.3	12.3	16.6	10.7	9.3	10.4	5.4	4.7
Slavonic	2,474	37.0	15.3	14.4	7.3	10.0	6.6	5.7	2.5	1.2

The correlation of mental deficiency with other neuropsychiatric conditions gives important information both as to mental deficiency in relation to the United States average for white persons and in relation to its average distribution among the negroes exclusively.

Of the first, Table 6 shows that, with the exception of mental deficiency and epilepsy, the negro falls below the United States average for all neuropsychiatric conditions. The negro falls much farther below both white and negro average for all these conditions in seven states in which he exceeds the negro United States rate for mental defectives. An undue distribution of mental defect inevitably necessitates a falling off in other neuropsychiatric conditions; but, as stated before, when mental defect is above the average, the falling off affects especially mental diseases, constitutional psychopathic states, and inebriety.

The provost marshal-general, in his final report, credits the negro draftee with a somewhat better physique than the white. The present statistics bear this out as far as the two neuropsychiatric conditions that have a definite physical basis are concerned—namely, neurologic conditions and endocrine disturbances. The particular distribution of neuropsychiatric defects among negroes points them out clearly as a primitive race. Physically, they may be above the average of the people with whom they associate, but they are far below that average in mental capacity.

It will hardly be possible to determine what better social opportunities and education will do for negroes before the present high incidence of mental defect among them is reduced.

American Indian.—(Number classified, 124.) The American Indian—or Amerindian, as H. G. Wells calls him—is primitive like the negro, and exceeds even him in mental deficiency. He is not as much below the United States average in alcoholism or drugs as the negro, and is somewhat below the negro in epilepsy, as indeed he is below the United States average in that disease. In other conditions—namely, neurologic, psychoses, psychoneuroses, endocrine and constitutional psychopathic states—he is far below the United States average. His high mental-deficiency percentage leaves little room for anything else. The small number of American Indians classified should be borne in mind when these statistics are considered.

Dutch.—(Number classified, 328.) The Dutch are close to the United States average in all groups. The indications are that they ingest more alcohol than drugs, but in both they fall below the United States averages. They have a few less neuroses and a few more of the other classified disorders.

English.—(Number classified, 9,092.) The English, like the Dutch, approximate the United States average in all groups. They appear more inclined to drink than to take drugs, and to have a slight excess of epilepsy, endocrine troubles, and constitutional psychopathic states. They just reach the United States average for mental defect.

French.—(Number classified, 941.) The French show rather a high distribution of inebriety, being considerably above the

average in alcoholism and only a little below it in drug addiction, their total percentage of inebriety distribution being 6.8 per cent as compared with 4.1 per cent for the English, and 4.0 per cent for the Germans. They also exceed the average in the relative number of cases of psychoneuroses, neurologic conditions, and epilepsy. They are considerably below the average in endocrine disease and are at the United States average for mental defect. The excess of inebriety in the French may surprise many, as the French are said to be a wine-drinking people and it is a common belief that wine-drinking people do not suffer from alcoholism. As a matter of fact, alcoholism depends on the actual amount of alcohol imbibed, rather than on the form in which it is taken. If enough wine or beer or any other beverage with comparatively low alcohol content is taken, a person becomes alcoholic. As far as France is concerned, large quantities of spirits are consumed in that country in addition to wines, and it may be that this custom persists among the French who live in this country.

The Native-Born German.—(Number classified, 4,164.) In spite of his reputed beer-drinking custom, the native-born German, according to the statistics, fails to reach the United States average in alcoholism and is not much given to drugs. On the other hand, he exceeds slightly the United States average in psychoses, neuroses, and constitutional psychopathic states, and in endocrine diseases by 3.5 per cent. He is slightly below the United States average in mental defect.

The Foreign-Born German.—(Number classified, 187.) The foreign-born German shows a much higher rate for insanity than the native born, but a considerably lower rate in endocrine diseases. Mental defect also is considerably less prominent.

Greeks.—(Number classified, 281.) The Greeks are very low in inebriety, especially as concerns drugs, but exceed the United States average in epilepsy, psychoses, and psychoneuroses, an excess particularly noticeable in epilepsy and psychoneuroses. They are well below the average in mental defect and constitutional psychopathic states.

Jews.—(Number classified, 1,314.) The American Jew shows a striking contrast in his habits of inebriety as far as

the choice of alcohol and drugs is concerned. The number of Hebrew alcoholic patients is almost negligible, while the percentage of drug addicts is more than double the United States rate. The percentage of neurologic conditions, epilepsy, endocrine diseases, and mental deficiency among Jews is also low. The low percentage of mental defect is particularly striking, the only classified races that show less being the Scotch and the Welsh. The Jew exceeds, on the other hand, the average representation in the conditions characterized by emotional instability. The percentage of insanity among Jews is nearly 2 per cent above the United States average and is very much above it for psychoneuroses and the constitutional psychopathic states.

Native-Born Irish.—(Number classified, 4,068.) The native-born Irish show the most pronounced tendency to inebriety of any neuropsychiatric group except the foreign-born Irish, and their intemperance relates to both alcohol and drugs. Inebriety constitutes 14.8 per cent of all their neuropsychiatric disorders. Approximately one-sixteenth of all the neuropsychiatric cases being found among the Irish, more than one-fifth of all patients with alcoholism were identified as Irish by the neuropsychiatric examiners and more than one-sixth of all patients with drug addiction. With the exception of inebriety, epilepsy, and constitutional psychopathic states, they sink below all United States averages. They are so far below this average in mental defect that they confirm the general law of the incompatibility of alcoholism and mental defect. They also furnish an interesting example of a high distribution of alcoholism with an under-average of mental disease. It would seem that if alcoholism were an important cause of insanity, one would find an excess of insanity instead of an under-average in a people so given to alcoholic intemperance as these people are. But in this connection it should be remembered that drafted men were too young to develop alcoholic insanity and also that alcoholic insanity among the Irish is more common in women than in men.

The Irish offer an interesting comparison with the English. There are 11.0 per cent more cases of inebriety among the Irish and 8.2 per cent less cases of mental defect. The

excess of alcoholism and the lesser amount of mental defect would indicate that they are a livelier, more excitable race than the English, which is borne out by their having a slight excess of constitutional psychopaths as compared with the English.

Foreign-Born Irish.—(Number classified, 394.) The difference between the native-born and foreign-born Irish in regard to nervous and mental diseases is that among those born in this country the distribution rate of mental defect is nearly 7 per cent more than among the foreign born, and among them also there is a higher distribution rate of constitutional psychopathic states and of endocrine disturbances. The average for insanity and inebriety, however, is lower. These are 9.2 per cent less in the distribution of mental disease among those born here. Inebriety changes both in extent and in its own distribution. There is a lessened total of inebriety of 4.2 per cent among the native born, and even a greater falling off in the distribution rate of alcoholism. About one-half of the decrease in alcoholism is accounted for by an increase in drug addiction among the native born. It would seem at first sight that this lowering of the distribution rate for insanity is to be connected with the lowering of the rate of alcoholism, but it should be observed that a similar decrease in the distribution of insanity occurs in the Germans, with a very minor decrease in alcoholism, and a smaller decrease in insanity among Scandinavians, with a larger decrease in the rate of alcoholism.

Also, as far as the Irish are concerned, the material increase in mental defect and in constitutional psychopathic states should be noted.

Native-Born Italians.—(Number classified, 413.) The native-born Italians present a distribution of neuropsychiatric disorders which indicate a sluggish, backward mentality. As drug addicts they rank higher than the Jews, and, like the Jews, are little given to alcoholic inebriety. Some races, such as the Jewish and the Irish, seem to be able to surpass the average in drug inebriety, and still, through the low percentage of other disorders that indicate racial backwardness, retain the characteristics of nimble-minded people. For example, the Irish, while they are excessive drug users, are

more given to intemperance in alcohol than in drugs; and of the two, alcoholic intemperance is indicative of more active mentality than is the secret and solitary use of drugs. Both the Irish and Jews, while exceeding the average in the use of drugs, are far below it in mental defect. But the Italians make the poorer choice for the satisfaction of their inebriate tendencies, and in addition to that, show their racial backwardness by a preponderance of those other disorders which must be accepted as indicative of inferiority. In mental defect the native-born Italians exceed the United States average by 4.7 per cent.

Foreign-Born Italians.—(Number classified, 2,039). The foreign-born Italian shows such considerable variation from the native born in the distribution of neuropsychiatric disorders that it seems that being brought up in this country has marked effect on him in this respect. The rate of epilepsy is much higher among the foreign born, but drug addiction is notably more frequent among the native born, as in fact it is among all the native-born foreign races except the German.

Mexicans.—(Number classified, 384). Of all races classified, the Mexican stands first in mental defect, the rate being 66.9 per cent. It exceeds that of the Africans and Amerindians. With the single exception of epilepsy, they are below the United States average in every other neuropsychiatric group. They seem to be swamped in their own dullness, and they cannot develop, to any great extent, any of the disorders that indicate an active or emotional intelligence. There was not a single alcoholic person among those examined and only two drug addicts, as contrasted with 45 epileptic patients and 257 mentally defective. One would hardly expect that a race so slothful as the enormous amount of mental defect found among them makes the Mexicans appear to be would be a drinking people. But it is rather surprising that they are free from drug addiction. Mexico is said to be one of the points from which opium (and its derivatives) is smuggled into this country, and one would naturally think that the Mexicans themselves would become addicted to the use of it.

The Mixed Races.—(Number classified, 23,604.) The mixed races include those whose ancestors were of different races. This group, of course, includes many "Americans". The

large number in it (one-third of the total number of cases) makes this group fundamentally important in the establishment of the United States average.

Native-Born Scandinavians.—(Number classified, 890.) Native-born Scandinavians (Norwegians, Danes, Swedes, Icelanders) show an excess of psychoneuroses, psychoses, and endocrine disorders. They are well below the average in mental defect and, almost as a corollary of this, in epilepsy.

Foreign-Born Scandinavians.—(Number classified, 366.) The foreign-born Scandinavians show much less mental deficiency than those born here, and, strangely enough, less endocrine disturbance. On the other hand, they show an excess distribution of alcoholism and insanity as compared with the native born.

The Scotch.—(Number classified, 579.) The Scotch exceed the United States average in all groups except that of mental deficiency. The mental-deficiency rate—16.8 per cent—is lower than that of any race, being below the United States average. This bears out the reputation of the Scotch for intellectual superiority. The inebriety is high, but as in all races that have a low mental-deficiency rate, alcoholism exceeds drug taking.

The Slavs.—(Bohemians, Bosnians, Croatians, Dalmatians, Herzegovinians, Montenegrins, Moravians, Poles, Russians, Ruthenians, Serbians, Slovaks, and Slovenians. Number classified, 2,474.) The Slavs have a high mental-deficiency rate, in spite of which their inebriety is alcoholic rather than narcotic, although both varieties are below the United States average. The comparative infrequency of epilepsy is worthy of remark, especially in view of the high rate of mental deficiency. In spite also of the sluggishness indicated by the excess of mental deficiency, they have an emotional sphere of some activity, as is shown by the excess of psychoses among them.

DR. PEARCE BAILEY

AT the age of fifty (1915) Pearce Bailey had made for himself an eminent place in medicine and neurology. A graduate of Princeton (1886) and in medicine of Columbia University (1889), he had later studied abroad, mostly in France, and had returned to enter the field of neurology. His early interest was in neuropathology and organic neurology, but he became interested in the traumatic neuroses and in 1898 had published *Accident and Injury; Their Relation to Disease of the Nervous System.* He was adjunct professor of neurology at Columbia from 1906 to 1910; consulting neurologist at St. Luke's, Roosevelt, New York, Orthopedic, Manhattan State, and St. John's Hospitals. He had served as president of the American Neurological Association during 1913 and as president of the New York Neurological Society from 1903 to 1905. He was a member of the American Medical Association, the American Psychiatric Association, the New York Pathological Society, and the New York Academy of Medicine. He had been one of the founders of the New York Neurological Institute and had served as chief of one of the sections.

It is interesting to note, however, that it was after 1915 that Dr. Bailey undertook and carried through the three undertakings that probably most distinguished his professional career—the organization of the Division of Neurology and Psychiatry in the Office of the Surgeon General, Washington, 1917, the chairmanship of the New York State Commission on Mental Defectives, 1919, and the organization of the Classification Clinic, 1920.

When it became certain that the United States would enter the World War, Dr. Bailey was one of those physicians who saw the importance of creating an army that would be nervously and mentally as well as physically fit. Previous to the declaration of war, Dr. Bailey, with Dr. Stewart Paton and Dr. Thomas W. Salmon, had been requested by the Surgeon General of the Army to make a trip of inspection to

the Mexican Border, where troops were then mobilized to study the facilities in the army for the treatment of nervous and mental patients. The facilities were found not to be adequate, and the Surgeon General requested The National Committee for Mental Hygiene to draw up proper plans for this branch of the army medical work and to organize neuropsychiatric units for the military hospitals. A special committee, known as the Committee to Furnish Neuropsychiatric Units to Base and Other Military Hospitals, and later as the War Work Committee, was appointed by the president of the National Committee, and Dr. Bailey was asked to serve as its chairman. Under his chairmanship, plans, including equipment, for special neuropsychiatric wards in base and general hospitals were prepared; methods for the neuropsychiatric examination of the army personnel, for the purpose of eliminating those nervously and mentally unfit, were drawn up; the preparation of special army psychological tests was assisted; a personnel of psychiatrists and neurologists was recruited, including a specially trained nursing and attendant personnel; and five graduate schools of neuropsychiatry were organized for the further training of medical officers.

At the request of the Surgeon General, Dr. Bailey accepted a commission as major in the medical corps of the army, and in July, 1917, reported in Washington to organize in the Office of the Surgeon General the Division of Neurology, Psychiatry, and Psychology. (The Psychological Section was later made an independent division.) Promotion to lieutenant colonel and to colonel followed. He served as chief of the new division until his discharge in February, 1919. In 1918 he spent three months in France on a trip of inspection. The most outstanding achievement of his work as Chief of the Division of Neurology and Psychiatry, aside from the successful carrying through of the plans already indicated, was the incorporation of the post of division psychiatrist in the tables of organization of the army. The creation of this post was of the greatest significance in that it assured to each army division a psychiatric chief who was responsible for the mental and nervous health of the men in his division: while in the United States, the elimination of the unfit was under his supervision,

and in the A. E. F. the organization of facilities for the immediate treatment of those who developed neuroses. For his services during the war, Dr. Bailey was granted a Distinguished Service Medal.

On completing his work in the army, Dr. Bailey was invited by the Governor of New York to accept the chairmanship of the State Commission on Mental Defectives. Long familiar with the clinical aspects of mental deficiency, Dr. Bailey had become, while in the army, impressed with the importance of mental deficiency as a social problem. He accepted the chairmanship. With his usual perspicacity, he saw his problem as a series of problems, and while attempting to coördinate them all, selected those that to him seemed of most immediate importance and with his quiet energy set about to solve them. In his thinking he at once separated the non-delinquent from the delinquent mental defective. For the former, he encouraged special education, either in ungraded classes of the public schools or in institutions, and supervision in the community after completion of the school work. He was particularly interested in the possibilities of supervised colonies from the state schools for the mentally defective. For the latter—the delinquent mental defectives—he created at Napanoch a special institution, the first institution for defective delinquents in this country.

Dr. Bailey had long been interested in the problem of the "different" or "odd" child, and particularly the problems of such children as they pass through adolescence. Although facilities exist for the care and training of the defective child and of the child who is definitely ill, either of physical or nervous disease, but little attention has been given to the supposedly "normal" child who is merely queer or difficult; he has rather been supposed to outgrow these difficulties and to take his place and compete with his fellows. Dr. Bailey's clinical experience had made him less sanguine of the later success of these children, and he believed that the nervous illnesses from which they came to suffer in their effort to adjust themselves in an adult world, or the mediocrity and lowered social efficiency into which they slipped, could in part be prevented by a proper study and understanding and ad-

justment of the child during its adolescence. To this end, therefore, he established in 1920, in connection with the Neurological Institute, a clinic of very great possibilities, which he chose to call the Classification Clinic.

Dr. Bailey was a director of The National Committee for Mental Hygiene and from the beginning contributed regularly to MENTAL HYGIENE. His last paper, *State Care, Training, and Education of Mental Defectives,* appeared in MENTAL HYGIENE the week of his death. In this number is reprinted, through the courtesy of the editor of the *Archives of Neurology and Psychiatry,* of whose editorial board he was a member, *A Contribution to the Mental Pathology of Races in the United States.* This article was published in the *Archives* for January and is the last of a series of papers Dr. Bailey published on the data collected during the war by the Division of Neurology and Psychiatry. Other important papers contributed to MENTAL HYGIENE are: *Efficiency and Inefficiency; a Problem in Medicine* (April, 1917); *Care and Disposition of the Military Insane* (July, 1918); *Care of Disabled Returned Soldiers* (July, 1917); *Applicability of the Findings of the Neuropsychiatric Examinations in the Army to Civil Problems* (April, 1920); *Mental Deficiency: Its Frequency and Characteristics in the United States as Determined by the Examination of Recruits* (July, 1920).

While Dr. Bailey chose to devote his professional life to neurology and psychiatry, he was not a specialist of narrow interests. His interests were broad and essentially "human". The early death of his wife and illness in his family tinged his own life with sorrows, but he never lost sight of the sorrows of his fellow-men, nor did he falter in his effort in their behalf. His work will live after him, like something that grows.

ABSTRACTS

Mental Disease in Cities, Villages, and Rural Districts of New York State, 1915-1920. By Horatio M. Pollock, Ph.D., and William J. Nolan. *State Hospital Quarterly*, 7:38-65, November, 1921.

The most striking contrast in environment in the state is that of New York City with the rest of the state. New York City is in a class by itself. Its population is composed of many diverse elements and new elements are constantly being added. It has the extremes of wealth and poverty and of luxury and wretchedness. The density of its population in some sections greatly exceeds that found in any other city of the state. Its crowded tenements, streets, subways, and elevated roads, with their many discordant noises, and the rush and whirl of business and pleasure demand adaptations on the part of the individual to a far greater degree than the relatively quiet environment of the smaller cities and other communities of the state.

We should expect, therefore, that the rate of incidence of mental disease in New York City, as shown by the first admissions to the civil state hospitals, would vary considerably from the rate in other parts of the state.

Table 1. Rates of Mental Disease in New York City and Other Parts of the State Compared, 1915-1920

Psychoses	First admissions from New York City		First admissions from other parts of the state	
	Number	Average annual rate per 100,000	Number	Average annual rate per 100,000
Senile	1,605	6.0	1,526	6.5
Cerebral arteriosclerosis	1,026	3.8	1,004	4.3
General paralysis	2,839	10.6	1,415	6.0
Cerebral syphilis	107	0.4	103	0.4
Alcoholic	949	3.6	713	3.0
With other somatic diseases	562	2.1	402	1.7
Manic-depressive	2,861	10.7	1,548	6.6
Involution melancholia	356	1.3	774	3.3
Dementia praecox	5,607	21.0	2,911	12.4
Paranoia or paranoid conditions	257	1.0	372	1.6
Epileptic	456	1.7	302	1.3
With psychopathic personality	354	1.3	314	1.3
With mental deficiency	432	1.6	472	2.0
All other psychoses	1,795	6.7	1,293	5.5
Total	19,206	72.0	13,149	56.0

The trend of population from country to city has wrought many other changes in the population of the state during the past three decades. In 1920, 82.7 per cent of the population lived in urban environment—i. e., in cities and villages of 2,500 inhabitants or more. In 1890 the percentage living in urban environment was only 65.

Table 2. Rates of Mental Disease in Urban and Rural Districts, 1915-1920

Psychoses	Urban first admissions		Rural first admissions	
	Number	Average annual rate per 100,000	Number	Average annual rate per 100,000
Senile	2,535	6.2	596	6.4
Cerebral arteriosclerosis	1,698	4.2	332	3.5
General paralysis	3,987	9.8	267	2.9
Cerebral syphilis	186	0.5	24	0.3
Alcoholic	1,510	3.7	152	1.6
With other somatic diseases	839	2.1	125	1.3
Manic-depressive	3,839	9.4	570	6.1
Involution melancholia	855	2.1	275	2.9
Dementia praecox	7,790	19.1	728	7.8
Paranoia or paranoid conditions	535	1.3	94	1.0
Epileptic	652	1.6	106	1.1
With psychopathic personality	558	1.4	110	1.2
With mental deficiency	702	1.7	202	2.2
All other psychoses	2,696	6.6	392	4.2
Total	28,382	69.5	3,973	42.5

Before the days of accurate statistics, it was frequently stated that there was a higher rate of mental diseases in rural districts than in cities, but judging from present well-established facts, the statement was never true. From the accompanying table (Table 2) it will be seen that in certain minor groups the rate of incidence is higher in rural than in urban districts, but the general rate in rural districts is much lower.

Of the 32,355 first admissions, 28,382, or 87.7 per cent, came from urban districts, and 3,973, or 12.3 per cent, from rural districts. The rates per 100,000 of the same environment were 69.5 and 42.5 respectively. General paralysis, alcoholic psychoses, and dementia praecox are predominantly city diseases. These, with manic-depressive psychoses, comprised 60.4 per cent of the cases from urban districts, but only 44.7 per cent of those from rural districts.

A Habit Training School for the Mentally Deteriorated. By Charles F. Read, M.D. *The Modern Hospital*, 18:135-38, February, 1922.

The regression to an extremely low level of behavior that is a characteristic symptom of dementia praecox was for a long time accepted as a necessary evil. "It was well known that spontaneous improvement took place at times in certain patients and that industry in general prompted habits of cleanliness, but little organized effort was made to produce this result upon a large scale as a part of a program for the betterment of this class of patients. Only within the last few years have the so-called 'untidy wards' of dementia-praecox cases been looked upon as an institutional reproach and the habit training of this group of regressives systematically undertaken.

"Illinois has been one of the first states to establish a state-wide program of occupational therapy, and as a part of this program at the Chicago State Hospital two wards for women, with a capacity of about 35 each, are set aside for habit training. They are structurally unsuitable, but are the best to be obtained. In like manner two larger wards of better construction are used for the male pupils. Upon one ward in each group are placed the more promising of the untidy praecox cases; very old cases and cases impulsively violent are excluded. The other ward serves as a promotional one for improved cases. To these wards are detailed intelligent attendants in charge of women of experience and sympathy.

"The following program, while elastic, outlines briefly the essentials of this work. It is not sufficient to direct the ward assistants in a general way to see to it that their patients are properly bathed, dressed, specialed, etc. They must be given certain things to do at certain definite times and required to carry these things out to the letter with the understanding that this effort, while necessarily routine in character, actually represents the early development of a movement away from the old-time hospital routine.

Daily Program in Habit Training Wards

6:00	Rising bell. Special, wash, brush teeth, comb hair, lace shoes, dress, air beds.
7:00– 7:30	Breakfast. Care of the wards for those who are able, make beds, sweep floors, etc.
9:00–10:00	Give water, special, care for nails, prepare for class.
10:00–11:00	Class work: kindergarten and other simple occupations.
11:30–11:45	Put up work and clean up.
11:45–12:00	Prepare for dinner, special, wash, etc.
12:00–12:30	Dinner.

12:30– 1:15 Care of teeth, special.
1:15– 2:30 Story telling and blackboard work.
2:30– 3:00 Give water, special, tidy up for exercises.
3:00– 4:30 Gym work on lawn if possible, if not in gymnasium. (Exercises should be simple and varied.) Walk.
4:30– 5:30 Special, rest, and make tidy for supper.
5:30– 6:00 Supper.
6:00– 8:00 Music. Patients dance on ward: their minds to be kept as pleasantly occupied as possible.
8:00 All to toilet, wash teeth, brush hair, put to bed with night gowns.
10:00–12:00–2:30–4:30 Night specialing.

"Here, as in the case of all 'programs', everything depends upon the spirit with which a difficult task is approached. The chief nurse, the occupational aid in charge of occupational therapy upon the ward, and the attendants must all be full of confidence that the object in view can be attained in spite of many discouragements. It is easy to write such a program, but no one who has not seen it put into practice can realize the pertinacity required for carrying it out successfully; not only pertinacity, but much sympathy and a faith that finds its justification in its works.

"Upon the other hand, when we remember that we are not dealing with the feebleminded, although these people behave in many ways like children, it can be more readily understood that this training in the individual case does not always progress in plodding fashion. These patients, as before stated, possess habit patterns that have not been destroyed, but have merely fallen into disuse. It is, therefore, not unusual to see a canalization occur quite speedily and the untidy patient become rapidly, almost suddenly, clean and interested in the work of the ward and in the special outlets for interest afforded by occupational therapy. These are the bright spots, the high lights in this work. Upon the other hand, there are patients that would test the patience of Job. There are some who never improve or improve only to backslide. Not all recover or improve sufficiently to go home, but considerable numbers do, as a result of training, attain to a higher level of living which makes it possible for them to lead a more comfortable, useful life, even though this life may remain institutional in character. Even from this latter viewpoint, it can readily be seen that this work is a benefit to the state as well as to the patient, since whatever benefits the individual cannot but realize a public gain. The patient who formerly required incessant care and rendered no service ceases to become in time an institutional problem and may even develop into a positive asset as an industrial worker. . . .

"At Kankakee 106 patients have passed through the habit training ward during the past year. Six were paroled home directly from the cottage, 5 more went home after being promoted to better wards. Twenty-two patients failed to show results and were finally demoted. Most of these were women who had been in the institution for more than fifteen years. A few were younger cases who seemed to be incapable of improvement. *Eighty-four were advanced to better wards* where they still are subject to some supervision as to personal habits and where they are occupied during the day. The class building at Kankakee is a singularly pleasant little cottage, skillfully remodeled for this purpose. Unfortunately no intensive work has been carried on with the male patients as yet.

"During this same period at Chicago State Hospital 196 patients were treated in the female habit-training wards and 87 were improved, 10 going home. Good results were also obtained upon the male wards, though not so striking, because they were not so well organized. For obvious reasons, it is more difficult to carry out this work with men than with women and its thorough development comes later.

"Now a word as to the *ideal* arrangement for such work. There should be at least two wards for each sex, preferably cottages of bungalow construction, one for the beginners and another for those promoted. The day room should be large, light, and airy, with drinking fountain, wash bowl, and mirror in the room so that all the patients may be benefited by observing those who make use of these facilities. The dormitory should not be crowded. There should be no single rooms, because all these patients are pretty much on the same level *and the endeavor to train them is a group proposition.* The toilets and bathroom should be separate. In the toilet the seats should be separated by partitions to give some degree of privacy and thus foster a return of the proper conventions. Lavatories must be generously supplied. The clothes room should be large and adequately supplied, not only with hooks for underwear and dresses, but with hangers for outside wraps, hats, etc. Much can be accomplished, especially with women, by appealing to their dormant desire to appear well. There must be a dining room upon the ward and the tables should be small, seating groups not larger than six each, preferably four. *There must be no crowding anywhere.* The paint should be attractive, even gay, in color, to which other decorations of one kind or another should be added, such as wall-paper panels, pictures, attractive hangings, rugs, plants, in fact everything that can be assembled to appeal in a well-bred manner to the patients' dormant love for color. There should be a phonograph in the day room with records that are fresh and often changed. There is nothing worse

for a patient than the constant use of old, cracked records. Animal pets or canaries should be allowed them if possible.

"The foregoing description applies to the male wards as well as the female wards. Both sexes should be supplied with non-institutional clothing in so far as possible. Strong dresses, drab-colored dresses, blue jeans, etc., are to be avoided. The extra care given should do away with the necessity of these familiar institutional garments.

"Upon the promotional wards there should be some more advanced occupation of a therapeutic character, such as wood sawing and sand papering for the men, doll making and simple forms of sewing or weaving for the women. These occupations, together with the necessary housekeeping that is always to be done, accord a considerable variety of outlets for the patients' energies. And the point to be emphasized is the fact that these activities, together with the habit training, are such as to bring the patient again into contact with reality and to lead him out of his self-absorption back into a measure of normal life. Even though this may remain a more or less restricted life, to a great extent routine in character, much has been accomplished in that the patient has been rescued from the profound delapidation that is almost inevitable in a large percentage of this class of cases."

CONTROL OF VENEREALLY DISEASED PERSONS IN INTERSTATE COMMERCE. By David Robinson. *Public Health Reports*, 36:2210-15, September 9, 1921.

The federal government has but little power to control the spread of diseases in the states. It has, however, passed laws that aim to prevent the spread of contagious diseases in interstate commerce. In addition, Congress has authorized the Secretary of the Treasury to promulgate regulations in regard to it. Under this authority, Amendment No. 7 was added to the Interstate Quarantine Regulations, which amendment regulates the interstate travel of venereally infected persons. It is not the object of the federal or state health officers to prevent venereally diseased persons who go to another state in search of medical treatment; but the amendment is aimed at diseased prostitutes, procurers, and vagrants, who not only neglect treatment, but deliberately expose others. Some states have adequate follow-up systems and notify other states directly or through the Public Health Service when an infected person ceases treatment without permission and goes to another state. No difficulty has been experienced in inducing such persons to resume treatment. Any persons convicted of violating the Interstate Quarantine Regulations who come from communities in which there is no provision for treat-

ment will be detained and treated at the expense of the United States Government. Much can be accomplished in controlling venereal diseases if a strong coöperation exists between the health officers of the various states. Another strong legal measure is the provision of state laws requiring that physicians report names and addresses and other facts relating to venereally infected patients who refuse to continue treatment or who are likely to spread the disease. Many physicians have been able to induce patients to continue treatment simply by calling attention to the existence of these laws.

BOOK REVIEWS

THE WORLD IN REVOLT: A PSYCHOLOGICAL STUDY OF OUR TIMES. By Gustave Le Bon. Translated by Bernard Miall. New York: The Macmillan Company, 1921. 256 p.

The author of this book is already well known for his many previous works, all of which approach important sociological issues from the psychological point of view. His thesis is an important one for the mental hygienist, and as he carries his argument along, he makes it very convincing that the future direction of important social, economic, and political movements can be wisely guided only as a result of psychological insight.

Le Bon traces the psychological factors that entered into the cause of the war and discusses the question of morale, the way in which morale was supported by the belligerent nations, and how its destruction resulted in the collapse of Russia and of Germany. He traces further the psychological factors that have operated since the war and are at the basis of existing economic disturbances and social and industrial unrest. And, finally, he takes up an examination of Bolshevism.

In his discussion of Bolshevism and other regressive movements, he calls attention to the principles that he has previously enunciated relating to the psychology of the crowd, and shows how the efficiency of society is dependent upon its *élite* and that it is impossible to substitute for them groups of untrained and uneducated individuals. Quantity in such cases is never able to take the place of quality. Society needs leaders, and when an effort is made at self-government through assemblages of large numbers of individuals of mediocre ability, the results can never be upon a sufficiently high level to insure progress and efficiency. An assemblage is a crowd and can meet in agreement only at a level that the constituent elements possess in common, which means practically the wiping out of all the superior traits and the dropping to a lower level of reaction.

The author also emphasizes, what should be well known facts, that beliefs are affective in origin, that they spread by contagion, and that they are not controllable by logic and reason—the same sort of conclusions that we are familiar with in the field of the psychoses. He argues, therefore, that the origin and the growth and the understanding of beliefs should be adequately investigated, so that effective ways of dealing with false beliefs and of propagating potentially valuable ones could be discovered.

While the reader may or may not agree with certain of the specific conclusions of the author, he cannot but agree that the method of approach to these problems as outlined is one of sanity and judiciousness and is the method of science rather than of political opportunism.

WILLIAM A. WHITE.

St. Elizabeths Hospital.

THE ANALYSIS OF MIND. By Bertrand Russell, F.R.S. New York: The Macmillan Company, 1921. 310 p.

It satisfies the indolent side of being to dream of resolving the pluralities of life into a future oneness. Creative science is animated by a different spirit. It represents the phase of being that is stimulated by the multiformities of reality. It delights in the many manifestations of the functional activity of reality as it is roused to their investigation. Continued investigation also leads away from fixed conceptions which hamper thought by insoluble perplexities. Thought is invited always to seek something behind the more manifest phenomena. This is not to find an ultimate unity of origin where at this end one can rest from change. It is rather to discover a unity out of which all the inspiring varieties of manifestation arise to reveal the dynamic versatility of reality. Therefore, if science leads thought thus, it stimulates it to share in the activity of reality, not to seek release from it.

Such is the healthy tendency of Bertrand Russell's investigation of mind. He expresses the spirit of much of the philosophy of today and of the psychological investigation that supports it. He introduces us not to facts which in their final convincing power satisfy thought once and for all. On the contrary, there is a stimulating uncertainty in his own mind as to the statements that he puts forward. He uses them merely as tools for the opening of paths of investigation that lie in the future of thought. He aims chiefly to convince himself and his readers that behind the apparently insoluble difference between mind and matter there is a common background of more primitive stuff. Mind and matter are then only different constructions of this original material. Physics groups the particulars of any portion of this reality "by their active places"—that is, as these particulars proceed from such object as its effects or appearances in different places. Psychology, on the other hand, groups particulars "by their passive places"—that is, by the appearances or happenings as viewed from a given spot. Psychology is distinguished by its own causal laws which might be named subjectivity and mnemic causations.

It is not necessary, under such a view of only a causal difference

between physics and psychology, to call oneself an idealist or a realist. A realist Russell asserts himself to be only as regards sensation, which represents the intersection of the physical and the mental. Beyond sensation mental phenomena obey certain other causal laws than those operative in physics. The duality of the two systems lies, therefore, not in their material, but in their causal relations to reality.

Russell occupies himself with an investigation of mental phenomena for the proof of this view, in order that thought may be led further into such a greater freedom with its material. He inquires into some of the possible fallacies of older conceptions which have prevented such elasticity of attitude. He examines consciousness in doubt of the correctness or the scientific usefulness of its assumed position as the essence that constitutes the uniqueness of mind. It is not a universal characteristic of mind nor is it so simple a thing as has been assumed. It is not, therefore, a primary distinguishing characteristic of mental life. Russell cannot reduce his thought to the mere materialism of the behaviorist. He acknowledges the debt that advance in psychology owes to the behaviorist's point of view in sharpening thought to the observance of response to stimuli and the importance of the latter as at least a practical phase of knowledge. In his view there is, however, something more to be taken into account. He considers that there are not only grounds for relying upon introspection to a modified extent, but a necessity for it in order to reach certain mental functions that elude merely external observation.

Perception, memory, and belief, he goes on to show, are factors that have their part in mental life. Desire with pleasure and pain—or discomfort, as he believes the latter idea is to be more accurately expressed—are also not to be left out of account in the attaining of cognition. He proceeds to investigate these elements separately to show them as not only existent, but trustworthy for psychology if they are considered as part of the causal system which distinguishes the psychic life.

His discussion of instinct and of desire brings us to the more fundamental nature of these, a recognition of which delivers them from the fallacious confusion with which they are commonly obscured. He leaves out the static cataloguing of "instincts" with which psychologies are too often cluttered. Yet one could desire greater clearness between various "instincts" and the pure conception of instinctive manifestation that serves vital needs. He might have kept himself more distinct in regard to reflexes and habits, both of which are means acquired for serving instinct and therefore rather more sharply to be distinguished from instinct itself. He admits the "complications which blur the sharpness of distinction" here. It is

a blurring that somewhat pervades his later discussion. He does well, however, in releasing the conception of instinct from an idea of prevision. Only its service in bringing to pass, directly or through whatever complicated acquired processes, the satisfaction of needs might have been brought to clearer statement. He has pointed in this direction, however, thus turning the reader toward that greater simplicity.

This conception is clearer as he carries it into the discussion of desire. He has allowed himself to be confused as to the position of psychoanalysis, even while he acknowledges the aid of the latter in certain directions. He himself distinguishes in an exceedingly useful way between the desires one thinks one has and those that are deeper, perhaps inherent, and usually concealed. He complains about the air of mystery that psychoanalysis seems to have thrown about the subject of desires. Did he know psychoanalysis more practically, he would realize that it is engaged in the very work he advocates—the separation, through clearer knowledge of the deception, of our consciously defined desires from our actual instinctive ones and the solving of the conflicts that such self-deception produces in the mental life.

The book is one of advance in the direction of a plastic attitude of thought and investigation. It presses not only into the deeper background for a psychological science, but a simpler statement and therefore a clearer understanding of the nature of the mental life. Thus does psychology come more definitely into its place as a cognitive science.

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New York City.

THE MANAGEMENT OF MEN. By Edward L. Munson, M.D. New York: Henry Holt and Company, 1921. 801 p.

Colonel Munson is an officer widely known as the designer of the Munson last of the army shoe. This volume thus represents a further sublimation and *Verlegung von unten nach oben*, in that, having previously aided us to walk comfortably as well as uprightly on the pedal level, he now offers us a guide to all our wills and ways. The book is a synthesis of military administration and psychological science. From the standpoint from which the psychologist can criticize, the result is successful. Our formulations are still in a very provisional stage, and in this as in any psychological work ideas must be voiced in regard to which common ground has not yet been reached. The sources of current psychological conceptions have been examined with understanding care. Authorities are not named, but the guess

is hazarded that McDougall has influenced the author more than has any other psychologist, to the good fortune of both.

Of comprehensive proportions, and of style clear and dry, the book lends itself to reference rather than to reading. The psychologist's impression is that the first part is too detailed, the second part not enough so; but the military reader might well take an opposite view. The earlier portion develops the system of psychology which the author applies to the problem of military morale. It is pointed out that the aims of modern war are essentially psychological, the creation of desired mental states in the enemy. German morale was built upon belief in superiority, and secondarily, if at all, upon faith in the abstract justice of the cause. Thus they did not stand up under reverses as well as did the Allies. Their morale system gave more attention to undermining that of the enemy than to upholding that of their own troops (Russia, Caporetto). Sometimes measures well enough calculated for their own racial psychology—such as the suppression of adverse news—were misapplied with enemy peoples ("frightfulness" in Belgium). The American soldier responds less well to direct commands and better to rationalization, or appeals to the group spirit. Stress is laid on the opportunities of turning perverted leadership to good account. (In Monckton, *Taming New Guinea*, it appears almost as a routine practice to sublimate the community bad man into a village constable.) An essential factor in mass appeals is simplicity, and especially something of the imaginal type; in which connection are discussed the flag, insignia, the slogan, the poster. A cause of fear is found in "blocking the instinct of self-expression", as seen in the shaken morale of reserve troops held under fire to which they cannot reply. This is a formulation interesting to compare with the Freudian conception of the fear neurosis. The relation between war and the "instinct of pugnacity" is perhaps more complicated than is made to appear. Certain objections might be raised against regarding such an instinct as the chief, or as other than a minor, factor outside the actual combat. But in general this discussion of the interplay of instinctive and affective processes is a portion of the book very commendable for collateral study by the psychologist. The remarks on hatred and shame are particularly well found.

The enumeration of the special points above is in no way to be taken as an outline or indication of the book's contents, which cannot be attempted in this note. Each chapter is headed by a summary of its contents. Particular mention might be added of the classification of the "mental and physical morale agencies" (page 54); the listing of the functions of the morale officer (page 320); the

text of the War Department circular on the duties of the morale officer (page 386); and the charting of the morale organization (page 390).

Further details of the morale system as conceived by the author are left to the student of his work, except that allusion may be made to the keystone of the system, the "morale operative". This vital functionary seems all too briefly dealt with. In the average military organization, members who have the special privilege and duty of reporting any feature of their comrades' conduct that may fit their subjective judgment of "morale" operation should occupy positions of unusual delicacy, to say the least. "An', Tommy, 'ow's yer soul?"

The reviewer is not able to name a more thorough assimilation of well tested psychological principles, or an application more consistent over a wider range of human behavior. It is gratifying when psychology of this kind is written by a psychologist; it is magnificent when it is written by one who is not.

F. L. Wells.

Boston Psychopathic Hospital.

The Eugenic Prospect: National and Racial. By C. W. Saleeby. New York: Dodd, Mead, and Company, 1921. 238 p.

This is a book on eugenics which recognizes that race deterioration may follow from environmental conditions. This in itself puts it in refreshing contrast to those contributions which are based on the belief that the germ plasm is somehow operating without any contact or influence from the outside world. In fact, it has become a sort of biological heresy to intimate that there are conditions that may change the germ plasm, and it has become a biological fetish that there is only one factor worth talking about and that is heredity.

Dr. Saleeby takes notice of the fact that valid experiments have been performed which prove that there are race poisons and that these race poisons may operate to produce defective individuals, and further, that this defect may continue from generation to generation. Medical men should not have needed these experiments to substantiate this belief, cognizant as they are of the fact that the same blood stream which nourishes and energizes the rest of the body nourishes and energizes the germ plasm. Those of us who live in a world of clinical realities will not be at all surprised to learn some day that a passing infection may injure the germ plasm and account for defective individuals for several generations, and that malnutrition may do the same.

Dr. Saleeby is a wee bit too enthusiastic about the eugenic measures of America. It is likely that the backward attitude of England

prejudices him in favor of our country, but no American need share his enthusiasm, though we may congratulate ourselves that we are a little better than our neighbors. Dr. Saleeby takes up the environmental poisons that in his opinion may injure the race. He thus speaks of alcohol, of diet, of the disgenic effect of war, and the revelations that the war has brought.

He finds it worth while for the eugenists to consider population pressure, and believes that in order to prevent future wars, which are horrible disgenic factors, "any society of nations must either provide for future modifications of frontiers in order to obviate the dangers of juxtaposition of one hungry, tightly aggregated population with another sparse and abounding in food, or provide for immigration and emigration so that these dangerous inequalities of population pressure with their explosive risks called wars may be averted". The orthodox eugenists seem on the whole to regard war as a good thing, and to believe that, like disease and such factors, it removes the unfit. That all the experience of mankind is against this view does not influence these doctrinaires. Though not original, Dr. Saleeby's chapters on this matter are worth the attention of every one who values the future of the human race.

The author points out the deterioration of the physical qualities of the inhabitants of the British Isles in trenchant fashion. He says, and quite truly, that youth has been neglected, and that owing to this neglect England is paying the penalty with a population of which three out of every four were found unfit for service. It may be objected that the mere fact that young people do not have sufficient food, live in dark quarters, do not play enough or properly, and start to drink and smoke too early, is of no importance to eugenics. The reviewer is very glad to second Dr. Saleeby in the belief that these things injure the germ plasm residing within these young men and women, and that a true eugenics must be a social hygiene as well. This, of course, is in direct opposition to a certain class of the eugenists who believe that all our measures of hygiene are merely keeping alive the unfit, and that as a result of medicine we have a process of disgenics at work.

One becomes lost in admiration of a eugenist who can pay attention to such a fact as the relative values of the kitchen range and the gas range. The kitchen range, according to Dr. Saleeby, produces the abomination of soft-coal smoke, and this poisons the urban communities and the urban inhabitants and thus is a disgenic factor. He goes into some length on the heating of homes and the doing away with smoke and dirt, not merely because these are good for the individual, but for the deeper and more important reason that they are good for the race.

Enough has been stated to show that Dr. Saleeby is dealing with the laws of hygiene and eugenics. He does not believe that nature and nurture are opposed to one another, but that bad nurture in its widest sense may produce what may become hereditarily bad nature. On this point, of course, he would be opposed by most biologists and by most of the eugenists of America, but if there is one thing that the 1918 epidemic of influenza showed, it is this—that epidemics do not necessarily select the weak and the unfit, but may select by preference the strong, the robust, the well-nurtured, and the well-natured. In the army camps of America and the world over, the husky young fellow of good family and fine physique was carried off by germs that hardly affected his runty, slope-shouldered comrade. In other words, if hygiene could have prevented the influenza epidemic, it would have prevented a factor tending to deprive the race of its best, not its worst. The diseases of childhood are not especially more frequent and more disastrous in those of poor stock than in those of good stock *except where the conditions of nurture protect the child.* On the whole there is no evidence to show that the best mental and moral types or the best physical types resist disease any better than do individuals inferior in these respects. Consequently hygiene is not opposed to eugenics. In pointing this out in a charming manner, Dr. Saleeby has done a real service, and his book should be read by all who have felt disheartened at times by a cynical attitude of eugenists towards humanitarian efforts.

A. Myerson.

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The Glands Regulating Personality; a Study of the Glands of Internal Secretion in Relation to the Types of Human Nature. By Louis Berman, M.D. New York: The Macmillan Company, 1921. 300 p.

After having read this volume of two hundred and ninety pages, we are racked by thoughts that crowd one another in their attempt to compel us to utter them. First of all, for whom was the volume written? Certainly not for the physician, for no medical work since the Middle Ages has made use of the flowery figures of speech that our young friend has in this work to drive home scientific facts. It makes one wonder whether the style is not, perhaps, incense to overcome our critical natures and disarm our reason. And then, having been thus overcome, we are treated to an exposition of what heretofore has puzzled our little minds and caused us to wrinkle our brows in perplexed thought for ages gone. Here are solved for us: the nature of memory, the reason for fear, the difference between terror and fury, psychoanalysis, why was Napoleon, and it even seems to the semi-

narcotized reader that somewhere in the volume there is given an adequate reason for the boiling heat of the sea and the sprouting of wings on pigs. While the subtitle states that the volume is a "study of the glands of internal secretion", it seems to the reviewer that the book gives a series of statements about them which have all at some time or another been made by many and various investigators—and most of them not sound at that—but as for a *study*, that would be far to seek.

Take the statement on page 88 relating to the pineal gland: *"Imagine it! somewhere, stuck away in a cranny of the floor of your head and mine, is this descendant of an organ that once sparkled and shone, wept and glared, took in the stars and hawks and eagles, and now is condemned to eternal darkness and an ineffectual sandiness. To-day we have not discarded that view of history"*, etc.

Here you have, *in parvo*, the entire book! The anatomy is wrong, the comparative morphology is wrong, the interpretation is wrong, and modern medicine has for some time recognized that the above historical view is also wrong. First, to be more explicit, the pineal gland is not in a cranny of the floor of the skull. Secondly, the pineal is probably not a vestigial structure related to the third eye of the lower vertebrates, but is glandiferous. It grieves us to have to bother Frederick Tilney to support this view of the pineal structure. His exhaustive work on this particular matter stands unchallenged to-day. And finally, as for the tears that in the bygone ages this darkly placed vestige must have shed—they were probably crocodile tears anyway and so ought not to count.

And so we have decided that the book could not possibly have been meant for physicians.

Perhaps the psychologists were the envied class addressed. On page 176 we read: "Some people are not easily frightened, others are more readily frightened, and still others are of an extremely fearful nature." Why, we pause to ask, should this class inequality exist? Millions of words have been wasted on this problem. Berman states the fact to be that *"it depends upon the proportion of adrenal cortex to medulla secretion in them, and their reaction to fear stimuli is a pretty good measure of the ratio"*. Nothing simpler! We have a deep-seated feeling that the rôles of Mephisto and Faust are being reënacted and that the secrets of our existence have been peddled. And intellectuality? *"By intellectuality we mean the capacity of the mind to control its environment by concepts and abstract ideas. The ante-pituitary has been depicted as the gland of intellectuality."* Verily, no doubt remains. *"Character is a matter of standards in the vegetative system, and is the grand intravisceral barometer of a personality."*

The speed and energy and sureness with which the author delivers himself of dicta settling questions that have bothered this little old world for centuries make us gasp. The use that he makes of theories that we recognize as belonging to friends of ours—who are not so sure of them themselves—by building superstructures of character traits, personality reactions, historical interpretations, is nothing short of marvellous. But are they true? Nowhere in the volume does he give us an inkling of his own experiences or experiments with humankind. His material is drawn from newspaper reporters, moving pictures, and historical sketches. Truly a vast fund from which almost any kind of material suitable to one's theories may be found. Anything can be proven about everything. But psychology! Heaven save the mark!

It must, therefore, be to the lay reading public that Berman addresses himself. His title, as with all titles, need have no bearing on the subject matter whatever. The subject need but be interesting, mystic, couched in highly figurative speech, without any serious consequences even if occasionally self-contradictory, and ought to touch upon all the newest themes in vogue in the "Village". This makes interesting reading, creates subjects for dinner discussions among the *male-female* and *female-male* habitués of the place, and so keeps them happy and busy. And so the book has its place.

To catalogue the errors, the unproven statements, the many self-contradictory deductions, would be to catalogue the two hundred and ninety pages individually with a special glossary. It would be wrong, however, to say that there is nothing worth while in the book. For every theory, from Crile's "kinetic drive", through Rogers' "check and drive" and Timme's "compensatory syndrome", is cited, though not always with authorship credit, and the use made of these bases for the author's purposes is, to say the least, interesting. That the glands of internal secretion do have a bearing upon personality reaction is almost certainly true; that the relationship is one of control is just as certainly overstating the matter; but, in any case, simplicity in the mechanism is unthinkable. Some of the cruder interrelations that Berman describes have also been tentatively advanced by others and may be said at this date to be borne out by our experiences with many of our cases. Fascinating as speculation may be, it is much wiser to analyze the conduct of our patients with coördinated laboratory, clinical, and psychological methods than to hope to predicate conduct and behavior from the grossly physical exterior alone. We should like to have Berman give us a really scientific exposition of one or two of his adreno-centric individuals—or adreno-tropes, as Joseph Fraenkel called them—with the laboratory findings, the psy-

chological reactions, the physical determinants, and his reasons for basing their personality reactions upon the comparative size of adrenal cortex and medulla. The book will undoubtedly find many interested readers—but, let us hope, discriminating ones.

THE NEW PSYCHOLOGY AND THE TEACHER. By H. Crichton Miller, M.A., M.D. London: Jarrolds, Ltd., 1921. 231 p.

That education is to be profoundly affected by the new data psychologists and psychiatrists are collecting in regard to the intellectual and emotional life of individuals, one feels quite sure. The influence of these data can already be observed, but scarcely more than a beginning has been made. A number of books dealing with the subject have been issued during the last two years, but on the whole they have been disappointing. Some have been almost fantastic in the size of the air castles their authors have had the courage to build on very slight foundations—like much that is now being put out for popular consumption on the important subject of glandular therapy. Others have been of very considerable value to the professional student of psychology or psychiatry, but quite too technical and involved for the teacher or parent. One welcomes, therefore, Dr. Miller's book. One may not agree with all that he has to say, but everything that he says is worthy of thoughtful consideration by all who have to do with children. He does not build fantastic air castles, and he has written simply and clearly. It would not seem that any intelligent person should have difficulty with the book.

Dr. Miller's point of view can probably best be given by quoting him. "There are roughly two aspects to education", he says, "the one the transmission of racial experience; the other, the development of the individual psyche. Each makes a different demand upon the child; and, if the teacher is to get below the surface in his educational methods, it is essential that he should set himself to realize the meaning of these demands that are made by himself or others, and also to understand the nature of the child's reaction to them." As to the development of the individual psyche, we may speak of it broadly "as self-realization, using the term to include the complete adjustment of the individual to life in all its aspects. Towards this goal the child is impelled by an energy which is not derived from the influence of parents or teachers or from any external force. The impulse towards growth is simply the biological urge to completeness which is found in every living thing. We come into the world with it, and it remains as the constant impulse towards a goal which is only attained when we reach maturity, and either express or sublimate

all our instinctive ambitions and potentialities. It is not primarily spiritual, but biological, and it is largely unconscious. It follows that a great deal of a child's growth, a great many of his ambitions and aspirations, are directed towards the primary, central, and perfectly unconscious motive of ultimate parenthood, because this is the essential biological expression of maturity. The human herd has become so complex and bewildering a thing that this great fact of parenthood being the token and visible symbol of maturity is largely obscured. Moreover, the human ideal of development is not purely biological, but has become enriched by ethical, social, and religious conceptions. In spite of this, the original biological nature of the impulse to growth and to completeness is not to be ignored.

"It is evident that, though this principle of growth is universal, it is not irresistible. It is infinitely liable to hindrance and deviation and delay at all points. The child's development toward completeness is very easily thwarted. If the urge to maturity is primarily biological, the barriers in its way seem to be almost invariably psychological; and for these barriers parents and teachers are commonly responsible. We put up a barrier when we restrain children unnecessarily; when we put difficulties in the way of their self-expression; when without reason we demand that they should inhibit interest and activity which seem to them to be perfectly harmless. This is the barrier of authority. The second barrier is raised when we offer to the child a world that is too harsh, too puzzling, and too difficult for its powers of adjustment. This is the barrier of reality. These are the two great problems of the child; and the test of his achievement is whether, when he reaches maturity, he has made the three great practical adjustments that life demands: the adjustment to society; the adjustment to the mate (actual or potential); and the adjustment to the Infinite."

Dr. Miller than proceeds to discuss the part that suggestibility plays in the adaptation of the child to authority and of phantasy to reality. These two chapters, it seems to me, are exceedingly suggestive. One would like to quote largely from both if space permitted. Of particular interest is his discussion of the rôle of fairy tales in the life of the child. A chapter on the emotional development of the boy and one on the emotional development of the girl present a point of view that is familiar to students of analytical psychology, but that is likely to be new to many teachers and parents. There follow chapters on unconscious motives, mental mechanisms, dream symbolism, the herd instinct and the herd ideal, and a final chapter on educational methods.

In his introduction, Dr. Miller points out a defect in his book:

"The limits of the book have made it unavoidable that some subjects should be touched upon with a misleading degree of simplicity." A reviewer feels this defect, particularly with such a chapter as that on dream symbolism. To discuss dream symbolism clearly in twenty-three small pages is practically impossible, and not to discuss it clearly in such a book is likely to cause confusion and misunderstanding. But in a book so excellent this is a minor point, even if one to be regretted. Dr. Miller has done parents, teachers, and mental hygiene in general a service in making available in this book a series of lectures that must have caused those educationalists who first heard them to become very thoughtful.

FRANKWOOD E. WILLIAMS.
The National Committee for Mental Hygiene.

SEVEN AGES OF CHILDHOOD. By Ella Lyman Cabot. Boston: Houghton Mifflin Company, 1921. 321 p.

At this epoch of social development, during which period the child-welfare problem has become firmly fixed as a part of a great public-health movement, Mrs. Cabot presents this timely volume upon the seven ages of childhood. The book, as the author states in the introduction, is a sketch of childhood, divided into seven overlapping periods, from the time of birth up to and including the "coming of age", the period in which serious problems of various types present themselves both consciously and unconsciously.

The development of the first three years of life is covered by the first book, *Babyhood—The Dependent Age*. The author refers briefly to many of the developmental reactions to which the average child readily adjusts himself and hints at the early appearance of responsibility. Book two is *The Dramatic Age*. This is the age of real childhood. The child's creative fancies, as brought forth by the imagination, are of immense value in opening up the secrets of this mysterious world, when properly guided and directed. Book Three, *The Angular Age*, treats of that period of latency during which many so-called "faults" develop and from which the child is attempting to free himself. *The Paradoxical Age* and the *Age of the Gang* (Book Four and Book Five) deal with the pre-adolescent and adolescent periods. The author describes the disharmonies existing between the brain (mind) and the body; she notes the frequent occurrence of opposite traits in conduct and behavior; and she observes the lack of sincere understanding as a factor in producing these disorders. The Sixth Book, or *The Age of Romance*, discusses the unfolding of the emotions. During this period the individual is concentrating all his efforts upon the adjustment of himself to himself and to society.

A proper adaptation throughout this age brings him to the development of his ambition, the choice of a vocation, and the reaction to marriage, as is discussed in Book Seven, *The Age of Problem.*

The traits manifested in these various stages will serve as indicators, not only in the normal development of the individual, but also in the abnormal. A keen observer may utilize such factors to open the pathway for a deeper study into the personality and the harmonizing of that personality in the family circle, in the choice of friends, or in society.

In conclusion, it might be said that the author has presented the story of child development to the layman in a very readable form; the book will be most useful to all workers in the field of child welfare.

FREDERIC J. FARNELL.

Rhode Island Society for Mental Hygiene.

TRADE TESTS: THE SCIENTIFIC MEASUREMENT OF TRADE PROFICIENCY. By J. Crosby Chapman, D.Sc., Ph.D., with the assistance of Daisy Rogers Chapman, M.A. New York: Henry Holt and Company, 1921. 435 p.

When Dr. Goddard, in his Vanuxem lectures at Princeton (later gathered together under the title *Human Efficiency and Levels of Intelligence*), proclaimed the logical necessity for social control of the 96 per cent of infra-superior minds by that 4 per cent that Giddings calls the "protocracy", he reached the crux of his argument in the question of confidence. That it would be desirable if the "best" minds could govern has been a commonplace, in the world of ideas at least, since Plato. That mankind would be happiest and most efficient if every human being were doing the work to which he is best adapted by nature is a thesis almost equally old. The only new and shocking notion was the finding of contemporary, and especially military, psychology that the actual distribution of individual mental differences in a representative cross section of humanity is so different from our preconceived equalitarian beliefs. Dr. Goddard said:

"Whenever the four million choose to devote their superior intelligence to understanding the lower mental levels and to the problem of the comfort and happiness of the other ninety-six million, they will be elected rulers of the realm, and then will come perfect government—aristocracy in democracy."

They might—given those ideal conditions. But that is just the rub. The establishment of the "aristo-democracy" awaits the perfecting of a technique of confidence. Such revelations as these have always aroused—and there is no indication that they will not continue to arouse—in the breasts of the great average only resentment,

incredulity, and opposition. A failure to recognize this fact has been the most conspicuous deficiency hitherto of the eugenists, the clinical psychologists, the line-and-staff officers, the efficiency experts, the personnel managers, and other groups in positions of power and influence, when called upon to deal with these problems of intelligence levels. Their social psychology is marred by a blind spot that will not permit them to earn that essential confidence. They have not devised a methodology of adaptation that appeals to the sense of justice and satisfies the affective demands of the rank and file of industrial workers. Here and there, emerging from the conventional disciplines of varied sciences, certain minds have glimpsed light on this problem and have begun to grope toward a psychology to meet it—Parker, Southard, Marot, Veblen, Link, Tead, and others. The economists and the psychiatrists are meeting each other with open minds now.

A prime factor in the creation of confidence, and one so far largely lacking, is the objectifying of methods in such form that the worker cannot question their impartiality as well as their efficacy. A new current, arising in "applied psychology" and bearing fruit in the work of the Army's Committee on Classification of Personnel, has now turned its attention to civilian industry. Dr. Chapman's valuable book is the record of that growth by one who has been through the thick of it and who, with the possible exceptions of Drs. Scott, Thorndike, and Bingham, had more to do with it than any one else.

Trade Tests is not intended as a contribution to the psychiatry of industry, and such principles as it utilizes of this nature are incidental, but they are symptomatic. Speaking of the kind of employment interviewing in which "the whole object of the procedure seemed to be to prevent the 'interviewer' from appearing to lack thorough trade knowledge", the author says (p. 365):

"When the examiner is out of his depth, the skilled workman is the first to detect the fact. Under these conditions, he feels that he is either passing through a purely formal examination or else that he is being made a fool of. Both of these situations are unfortunate for the reputation and effectiveness of the employment office. All who have worked in industry know how important it is that a good understanding exist between the various shops and the office, an understanding that should not be confined merely to the foreman, but should extend to each man in the plant."

Varying types of trade examination have varying values here in respect to the morale of the men. But Chapman believes that the importance of this point can be overestimated. In examining several hundred men each day for several weeks, in eighty trades, in a large

employment office, he found only four cases in which the applicant openly expressed his skepticism and disapproval of the oral examination (p. 384).

The book is mainly a straightforward account, with copious examples, of the nature, construction, and administration of the army trade tests, together with some more speculative chapters on the analogies of the military to the industrial problem and the application of trade testing to the latter. The trade tests grew out of a series of arbitrary questions called "aids to interviewers", designed to meet the emergency during the early days of the war. Analysis showed that the army utilized somewhere or in some part of its organization the astonishing number of 714 distinct civilian trades and occupations. The waste involved in fitting millions of recruits to these niches by the haphazard trial-and-error methods that first obtained—and that still largely prevail in peace-time industry—cannot begin to be estimated.

Some means had to be devised to differentiate between various degrees of trade ability, on the assumption—which later became almost a fixed law—that there is so high a correlation between the elements of information and skill in a given trade ability as to make the possession of the former a reliable credential of the presence of the latter. Individual interviewers could ask arbitrary questions covering an entire process, the answers to which might vary widely in scope and acceptability. On the strength of such answers, they could give only subjective judgments of a tradesman's skill, with a large margin of personal equation. But eventually the substitute method was evolved of the objective "single-answer" question, necessitating no special trade knowledge on the part of the examiner, limited to a specific detail of the process, but one that is strategically essential to wider knowledge, and answerable, with but slight variations, in only one way for which credit can be allowed.

The story of how the completed and standardized trade test is built up is fascinatingly told by Chapman, but must be passed over here. Each test consists of twenty questions which, in sum, yield quantitative scores, "calibrated" to differentiate four grades of trade ability—the novice, the apprentice, the journeyman, and the expert. But the book is really a manual that would enable any intelligent personnel manager to build his own trade tests for specific trades.

Two alternative forms of tests were also devised for army use—the picture method and the performance test, both aiming to realize more fully than the oral test the actual conditions under which the trade is performed. Each has its advantages and is obviously adapted to certain types of trades.

The trade-testing movement is as yet but in its infancy. It has a distinct field of its own, not to be confused with that of intelligence tests, skill-prediction tests, or the ingenious techniques that are now being devised for measuring emotional and volitional elements of personality. It is a highly practical attack upon a crying socio-economic problem, based upon rigidly objective and statistical methods that are ultimately the genius of all science. It is a long step forward in the direction of a better adjustment between human capacities and material needs. That it will contribute illuminating insights to many psychological and psychiatric tangles is all but a certainty, and Dr. Chapman is to be thanked for providing the first authoritative discussion of the field.

KENNETH M. GOULD.

American Public Health Association.

STUDIES IN DREAMS. By Mary Arnold-Foster. New York: The Macmillan Company, 1921. 178 p.

This volume is an excellent lay example of the type of discussion that was common a few years ago in polemical medical literature in opposition to the so-called Freudian psychology; that is, the argument was that one believed in Freud's theories, but not to the extent to which Freud expounded them. The present book is a complete exposition of this view. It is unnecessary to say that the author's courage in giving an account of her own dreams is equaled only by the obvious incompleteness of their interpretation, however fair and open-minded she seems in her approach to this task. No violence is done to the general Freudian doctrine of dreams except, perhaps, in a few instances. The manner in which the author believes that the so-called power of conscious will can direct the unconscious dream thought, and thus alter the character of the dream, is an instance in point. If the author means that she consciously desired to dream flying dreams in their general trend, well and good; this may be possible. Again, referring to her chapter on dream control, that the conscious will may be able to strengthen the censor or semiconscious resistance to that point where the conflict becomes too great for the nightmare to proceed, and thus awakens the individual—this, too, may be possible. However, the general proposition that the conscious may be taught actual will control over unconscious activity in dream content seems quite contrary to our clinical experience. It is interesting to note that in all her flying dreams the author's behavior is as if she were moving in a fluid rather than through air, thus tending to prove that these dreams of omniscience are really regressive in type, analogous to instances of metro-erotism cited *in extenso* by many of us in neuroses and psychoses.

A clever and adroit foreword of eighteen pages by Morton Prince commends the volume, especially those parts that lend support to his well-known interpretations of dreams and his antagonism to many Freudian concepts. The important chapter headings are: *Dream Control; Flying Dreams; Dream Recording; Dream Memory, Dream Imagination, and Dream Reason; Symbolism in Dreams, and the Significance of Dreams in Tradition; Dream Places; Dream Construction; Sense Impressions in Dreams; The Actors in Dreams; Moral Sense in Dreams.*

The author's literary style is simple and thoroughly enjoyable reading, though seemingly too naïve for one so skilled in writing.

New York City. L. PIERCE CLARK.

THE CONTROL OF SEX INFECTIONS. By J. Bayard Clark, M.D. New York: The Macmillan Company, 1921. 132 p.

This is a very readable little book. The author served in the Medical Corps during the recent war with great credit to himself and, if one may judge by this publication, his experience was extremely profitable.

The first six chapters outline in a very general way the whole situation as regards the venereal-disease problem. These chapters are excellent reading, though there is very little in them that is new. No one could possibly contest a single point. In fact, the whole field has been covered so many times before that one begins to wonder what excuse there is for writing it all again. Here is the excuse—the author's solution of the problem, which is as original as it is ingenious. This is it—universal military service for youths and compulsory summer camps for girls, physical upbuilding, sex instruction, and vocational training, the last for the purpose of making possible early marriage, well recognized as one of the best means of preventing venereal infection. And all of this for all the boys and girls of the nation at the age of greatest receptivity. This is not all of it, but it is really the high point—the excuse, and a sufficient one, for the publication. In addition to being a new argument for universal service, it is a genuine constructive program in the campaign against sex infections.

It would not be fair to conclude without mentioning two more points—namely, the style, which is delightful, and the description of the author's tactful and efficient administration of his war hospital.

Dr. Clark concludes his preface as follows: "Though I remain acutely conscious of the many shortcomings of this small volume, I still trust that it may prove to be in some degree suggestive." The contribution is more than suggestive; it is material for serious thought. HARRY N. KERNS.

Medical Department, U. S. Military Academy, West Point.

MANPOWER. By Lincoln C. Andrews. New York: E. P. Dutton and Company, 1920. 150 p.

This book is said by the author in his foreword to be an adaptation of a previous volume called *Military Manpower*, his purpose being to apply the principles of army leadership to the social and industrial problems of civil life. No doubt an acquaintance with the preliminary work would be desirable as a basis for a fair criticism of the present one. Such a knowledge the reviewer lacks and acknowledges that in so far his opinion should be discounted.

The impression is gained, in the first place, that the author is a good officer and an upright, kindly gentleman, with a deep interest and respect for those of his fellow-creatures who happen to be under his command in any capacity. At the same time there is much of benevolent paternalism in his attitude in spite of his emphasis on real democracy.

He has made the attempt to draw from his broad army experience in handling men general principles that may be of use to others in any capacity of leadership, whether it be as foreman of a construction gang or governor of a state. In doing this, he appears to have gone considerably beyond his depth and to have floundered for a hundred and fifty pages in a sea of generalities without special course or direction.

Some sermons leave the hearers with a comfortable feeling of having had the trite and the obvious well presented in a manner not to cause a ripple on the smooth surface of their complacency. Thus one may read this book, agree heartily with its doctrine, and yet feel that neither in knowledge nor power has one added one whit to one's previous capacity.

The author's attempt to divorce his teaching from the special viewpoint of military relationships has not been altogether successful. The whole discussion seems to hover around the company or regimental organization, and to be held away from it for general application only by forced manipulation.

To the unformed mind of boy or man, there will be points of value in this book. Its usefulness to those with any degree whatever of executive experience will be doubtful.

MARTIN W. PECK.

Boston Psychopathic Hospital.

JUVENILE DELINQUENCY. By Henry H. Goddard. New York: Dodd, Mead and Company, 1921. 120 p.

This is a readable, well-written little book. It discusses the causes of delinquency and crime, the organization of the Ohio Bureau of Juvenile Research, the results of physical and mental studies of juve-

nile delinquents by this bureau, and recommendations as to further studies and methods of controlling delinquency.

Attention is called to the fact that we are beginning to inquire why a child is delinquent and to learn "that disease and defect, mental and physical, are conditions favorable to the commission of offenses against the public". As a result, we shall examine all offenders, and those having disease or defect will be either cured or placed where they will no longer menace society. Most of our crime is not a necessary evil.

The author points out that many universal traits are more or less antisocial and must be controlled for the benefit of society, since the group is more important than the individual. If the individual fails in such control because he cannot understand (feeblemindedness), or because he lacks the ability to control (mental disease and psychopathy), he must be cared for medically, not legally as at present.

The chapter *The Psychopathic Child* is most interesting and instructive. The necessity of differentiating between feeblemindedness and psychopathy is clearly stated. "Psychopathic children differ from the feebleminded in that the former are diseased, while the latter simply have not developed." There is an excellent description of the psychopathic child. It is claimed that it is possible by psychological tests to diagnose psychopathy easily, and to distinguish normality, psychopathy, feeblemindedness, and psychopathic feeblemindedness, each from the others. The psychological test is spoken of as "an X-ray picture of the mind". This seems a fair comparison to the reviewer, since both psychological tests and X-ray examinations, even in the hands of experts, often fail to show diseased conditions and frequently show abnormalities that do not exist.

As to the causes of psychopathy, we are told that "a surprisingly large proportion of delinquency is due to congenital syphilis". Other causes given are fevers, infections and intoxications, "disturbance of the emotional system, which of course may act through the glands of internal secretion affecting the blood stream and thus the brain itself", and pushing ahead too fast "exceptionally bright children". As regards syphilis as a cause of psychopathy, it is stated that "enough is already known to make it reasonably safe to conclude that when there is syphilis in the parents and persistent bad conduct in the child, we are dealing with cause and effect". The reviewer feels that such a conclusion is illogical and that it is not fair to conclude that bad conduct in the child of syphilitic parents is necessarily caused by other conditions than those that cause bad conduct in children whose parents are not syphilitic.

The author frankly admits that but little progress has been made in the direction of treatment. The most important thing is the plac-

ing of all such cases under medical supervision until they are cured, and the folly of the present system of punishment by confinement for a stated period is clearly shown. As the author aptly remarks, one might as well commit an insane person for a period of one year as a delinquent.

The schools are rather caustically criticized. The author states that "the first business of schools is to socialize the child", render him fit to live in society, rule improper instincts, and teach him honesty and morality. No child whose intelligence is less than twelve years can understand abstract principles. Hence the schools will never socialize children with their present methods of teaching abstract principles to those of low intelligence.

There are several chapters given to an interesting account of the bureau's work in Ohio, and statistical tables and case histories are furnished.

The reviewer believes that undue emphasis is placed on congenital syphilis as a cause of delinquency, and he also feels that the author overemphasizes the value of formal psychological tests. However, the book on the whole is a welcome addition to the study of delinquency. It states clearly and concisely many important facts concerning delinquency and points the way to a more desirable method of treating this condition.

KARL M. BOWMAN.

Boston Psychopathic Hospital.

READINGS IN EVOLUTION, GENETICS, AND EUGENICS. By Horatio Hackett Newman, Professor of Zoology, University of Chicago. Chicago: The University of Chicago Press, 1921. 523 p.

The author has succeeded in presenting a very readable, non-partisan account of our present knowledge of evolution, genetics, and eugenics. For a general survey in this field we know of no better work, and the book ought to receive wide recognition as a dependable source book. One's pleasure in reading the book is very much enhanced by the extensive quotations from the original writings of the fathers of these sciences.

BERNARD GLUECK.

New York School of Social Work.

VON SEELISCHEN GLEICHGEWICHT UND SEINEN STÖRUNGEN. By Dr. Walter Gut. Zurich: Art. Institute Orell Füssli, 1921. 163 p.

This little volume consists of five popular lectures on mental equilibrium and its disorders, delivered by the author during the spring of 1920. The chapter headings are as follows:

1. *Mental Disorders on the Basis of Bodily Defects.*
2. *Disorders Based on Neurotic Disposition and Certain Types of Mental Constitution.*
3. *Disorders in the Developmental Career of Normally Constituted People.*
4. *Mental Disorders in the Individual as an Expression of the "Maladies of the Times".*
5. *On Mental Health.*

The author states in very clear and simple language the modern tendencies in psychopathology, and his contribution is thoroughly dependable.

BERNARD GLUECK.

New York School of Social Work.

AN INTRODUCTION TO CHILD PSYCHOLOGY. By Charles W. Waddle. Boston: Houghton Mifflin Company, 1918. 317 p.

The outstanding merit of this little volume lies in its clear and attractive presentation of the fundamental movements in scientific child study, experimental pedagogy, and behavior. It is conservative in that it all but ignores any contributions of the analytic schools in its otherwise very admirable survey and bibliography.

The topics for discussion accompanying each chapter are splendidly provocative of thought and greatly enhance the value of the book. There is fairly ample treatment of biological considerations, with a thoroughly satisfactory digest of fact and fable in mental inheritance.

The chapters on the moral nature of children and juvenile delinquency summarize the recent statistical studies in ownership, destructiveness, truancy, lying, obstinacy, teasing, bullying, and general incorrigibility, passing over with inadequate mention the subject of sex delinquencies.

As a resumé it is a very useful addition to the textbooks in child study, although it makes no pretense of offering original material or of being a comprehensive treatise.

MARION C. GOULD.

Vassar College.

EXCEPTIONAL CHILDREN AND PUBLIC SCHOOL POLICY. By Arnold Gesell, M.D. New Haven: Yale University Press, 1921. 66 p.

The author of this monograph is, if the reviewer mistakes not, the first university professor in this country to hold a chair devoted to child hygiene, and is also a well known specialist in mental hygiene. From such a well-equipped authority the reader expects a trustworthy and significant contribution, and he is not disappointed.

Dr. Gesell discusses the place and importance of mental hygiene in the public school and the question when is a school child exceptional. He notes that "humanity as well as hygiene requires that we recognize at least the most radical individual differences among our school children"; and in answer to the question when we should regard a child as "educationally exceptional", borrows the phraseology of the law and replies "an exceptional school child is one whose mental or physical personality deviates so markedly from the average standard as to cause a special status to arise with respect to his educational treatment and outlook".

The results of an important mental survey of 24,000 school children in the New Haven schools, from the kindergarten to the eighth grade inclusive, are presented. The children were classified as: (a) definitely backward; (b) very probably deficient; (c) doubtful; (d) merely backward.

Among a total number of 725 children reported under these rubrics, 270 cases of mental deficiency were found; and an examination of the school problems of these children "gives convincing evidence of the subnormal intelligence with which the school is obliged to deal". A series of graphs show the age distribution of these deficient children and reveal the following facts:

"71 children over 8 years of age cannot describe a simple picture;

"66 children over 8 years of age cannot copy a diamond;

"31 children over 7 years of age cannot read at all (only 39 out of 270 read fluently or with expression; the remainder read imperfectly, syllabically, haltingly);

"95 children, ranging in age from 9 years to 16 years, cannot write their whole name;

"126 children do not respond correctly to the simple question, 'In what city do you live?'

"109 children, ranging in age from 10 years to 16 years, cannot tell time."

Among other subjects considered are superior and atypical mentality, the relation between social status and intelligence, different types of exceptional children, school provisions for mentally deficient children, vocational training, proposed legislation, and the Connecticut Children's Code, which emphasizes the principle of local community responsibility and "the dependency of this principle upon adequate state organization and authoritative state supervision".

What happens to these subnormally minded children when they leave school, Dr. Gesell was unable to say with statistical accuracy. But he adds: "We may be certain that it is these very subnormal children who as youths and as adults may pile up for society a large burden of inefficiency, crime, vice, and dependency. It is always well to remind ourselves that our future social problems are concretely foreshadowed in the children who are now making a failure of school life—the children revealed by our mental survey."

WILLIAM H. BURNHAM.

Clark University.

CHILD WELFARE FROM THE SOCIAL POINT OF VIEW. By Nora Milnes, B.Sc., Director of the Edinburgh School of Social Study. London and Toronto: J. M. Dent and Sons, Ltd. New York: E. P. Dutton and Company, 1921. 243 p.

Every mental-hygiene worker, as well as every other kind of social worker, would probably agree with feeling with what Miss Milnes says about the relationship of social worker to physician. Until recently, she states, infant welfare has been regarded as a medical rather than a social question, but now it has very definite social aspects. "The person with an exclusively medical training can no more expect to tackle a social question unaided than a person with an exclusively social training can be expected to recognize and tackle the symptoms of disease. . . . The ordinary social worker may be painfully aware of his ignorance of medical questions, yet he may sometimes be led to wish that the medical specialist were as equally aware of his ignorance of the great social factors." She comments that just as the medical man has resented the intrusion of non-medically trained social workers into a field formerly exclusively medical, so, too, social workers now are finding it annoying that workers with no knowledge of or training in social work are dealing with questions evidently social. She is quite right. Social workers are becoming in their way as much a necessity as nurses to physicians, and yet physicians are unversed in the technique of social workers and do not meet them halfway. It is a pity that Miss Milnes does not urge that at least as much instruction be given in medical schools in regard to social problems as social workers get in lectures on medical subjects. Incidentally, it is likely that education of social workers will eventually result in education of the laity, sufficient ultimately to force medical schools to give some teaching with regard to social problems that are allied to the health of individuals and groups. This, however, digresses from Miss Milnes' book.

This book's scope is not broad, dealing with the dependence of the child upon such environment as money can buy. Miss Milnes says: "It is but too evident that poverty lies at the root of the whole problem that gives rise to the child-welfare movement." She regards the study of child welfare as one of applied economics, arguing that the whole science of economics is concerned with the examination of forces that are at work aiding or hindering man in his efforts to satisfy his wants, and that the social worker is usually concerned with helping to satisfy wants that otherwise would remain unsatisfied. The practical aim of the child-welfare movement she separates into two branches, the first being to reduce the infant-mortality rate, and the second to afford to the child a better chance to develop into a healthy adult. Although Miss Milnes feels that it is hardly to be expected that those will succeed in life who have had insufficiency of fresh air, good food, warmth, rest, play, and education, and who have lived in "sordid, material surroundings, ugliness unrelieved", she would have us hope that "all this we may try to tackle by dealing with the outer environment". She says nothing about child welfare among the well-to-do, though there is many a Poor Little Rich Girl besides the one Eleanor Gates portrayed. Would Miss Milnes say that the wealthy have no need of social workers?

In her chapter on the mother, she never pictures the mother of a large family happy, though poor, but always the mother who, although with no actual physical deterioration due to child-bearing, becomes nevertheless a drudge with lowered mental capacity and an irritable temper; "with no one to relieve her, no pleasure before her except those that are born of her maternal instincts, she not unnaturally becomes ill-tempered, nervy, and in every way unfit for her task". The author believes that the mother's irritability will make the child "shy, nervous, or even untruthful, . . . and since these factors are as important as the physical, then in our educational efforts it behooves us to do all we can to keep the mothers' outlook bright, cheerful, and alive".

Possibly Miss Milnes does have in mind the relationship of mental outlook and contentment to child welfare, but she gives it no space in her book. She would furnish contentment by external means. Many people believe every tub rests on its own bottom and that contentment must come from within oneself before real enjoyment can take place in one's environment.

A few times in the book, Miss Milnes very briefly mentions phases of the mental side of life. In one instance, she speaks of children being sensitive to injustice and unable to comprehend the attitude of the

adult; in another, she barely mentions the possibility of a child's joining the ranks of juvenile delinquents if he has been too much disciplined; and in another, she refers to the standard of morality a child is apt to have if brought up in a one- or two-room dwelling "in close contact with the grossest materialism". These are mere statements and are not dealt with, though many readers of MENTAL HYGIENE would consider them to be of as much importance to child welfare as are housing, food, and clothing.

Miss Milnes deals with the subject of child welfare entirely in its relation to economics. She does not mention mental diseases such as psychoses, neuroses, or feeblemindedness, and does not account for the existence of poverty in any other way than by conditions existing outside the individual. All those who have no training in economics would do well to read Miss Milnes' *Child Welfare*, but those interested in the mental welfare of a child will not find their wants satisfied in this book.

THADDEUS H. AMES.

New York City.

WILL POWER AND WORK. By Jules Payot, M.D. Translation by Richard Duffy. New York and London: Funk and Wagnalls Company, 1921. 422 p.

In reading this book, one is immediately impressed by the fact that it was written by a person who was not dealing with theories, but writing of what he knows. It might be called a practical technique of thinking. It describes the proper way to work, and instructs one in the importance and the best methods of using the mental faculties of attention and memory. The last two paragraphs of the translator's introduction well express the purpose of the book:

"In earlier days progress in the world was slow and painful because there was so much ignorance in all countries. Nowadays, as humanity strains and tugs feverishly to advance, it finds its chief obstacle to be the friction and hindrance caused in the general mind of the world because the great majority are partly educated or are over-educated.

"To supplement the education that is lacking, and to render assimilable the education that causes chronic mental indigestion, is the purpose of this book. It is designed to achieve that purpose, not through any mysterious and occult procedure, but through forthright expression of ideas, which he who reads may understand as he reads, and be guided to the knowledge that insures broadening and deepening of the mind as well as invigoration of the soul."

Dr. Payot has succeeded in producing a most useful and interesting work. Many educators would profit through reading it, and if a copy of it were to be placed in the hands of every college matriculant, the educational machines would turn out better educated individuals. This book needs to be read only once to be appreciated, but it deserves the careful study of every student who is searching for a practical technique of acquiring knowledge.

WILLIAM B. TERHUNE.

Connecticut Society for Mental Hygiene.

HOW THE MIND CURES. By George F. Butler, M.D. New York: Alfred A. Knopf, 1921. 286 p.

This is the story of a business man who in many respects is maladjusted, and of a doctor who attempts to reëducate him. It is written in dialogue form, and purposes to be a record of the conversations of the physician and the patient. The latter is a man of narrow interests, such as are encountered daily in many walks of life, and the doctor is a psychiatrist with an acceptable, if simple, philosophy of living which he succeeds in imparting to the patient. The book stresses the importance of fresh air, proper food, exercise, rest, seeking pleasure in work, and self-control. People of limited education will find it helpful, while those who have received a high-school training may be assisted through the reiteration of facts with which many of them are already familiar.

Dr. Butler is to be congratulated, in as much as he has written a book that will not suggest symptoms to the most suggestible patient.

WILLIAM B. TERHUNE.

Connecticut Society for Mental Hygiene.

MENTAL DEVELOPMENT AND EDUCATION. By M. V. O'Shea. New York: The Macmillan Company, 1921. 403 p.

Many readers of MENTAL HYGIENE will remember the wholesome influence upon education of O'Shea's *Dynamic Factors in Education*, published nearly twenty years ago. *Mental Development and Education* has been written to take the place of the former book and, although nearly all new in material, it is in the spirit of its predecessor. It is primarily for teachers and will surely prove popular and useful. It abounds in concrete material and is measurably richer in substance than O'Shea's first book. It nevertheless reveals in places a lack of knowledge of recent psychology. The discussion of fear as a motive force in development is an illustration of this fact.

ERNEST R. GROVES.

Boston University.

PSYCHOLOGY AND THE SCHOOL. By Edward Herbert Cameron. New York: The Century Company, 1921. 339 p.

Psychology and the School is written for students and teachers who have no previous knowledge of psychology. It presents in a clear, concise manner the type of educational psychology that has been built upon the psychology of a decade ago. Little reform in school practices can be expected until the meaning of recent studies in human behavior can be interpreted to teachers in an educational psychology that utterly discards the structural treatment of psychic experiences.

ERNEST R. GROVES.

Boston University.

APPLIED PSYCHOLOGY FOR NURSES. By Mary F. Porter. Philadelphia: W. B. Saunders Company, 1921. 172 p.

This book is written simply and for the general nurse; its contents justify its title. If it is touched by a New Thought phraseology in spots, this is in a laudable effort to emphasize older and valuable ideas. "I conceive of it as possible that every well-trained nurse in our country shall consider it an essential to her professional success to leave her patient imbued with the will to health and better equipped to attain it because the sick attitude has been averted." The general nurse is addressed, and the general patient is the subject, in contrast to Dr. Burr's *Practical Psychology and Psychiatry*, which addresses nurses and doctors on the subject of the psychiatric patient.

The consciousness of the normal person is considered in three chapters and the "normal mind" in three more. Consciousness is the "simplest mental reaction to what the senses bring", and the "unconscious is simply the latent conscious—what once was conscious and may be again, but is now buried out of sight". Throughout these chapters occur many similes that give clarity, perhaps, but that tend to inexactness. The sympathetic nervous system is "the direct connecting link between mind and body", and the wise nurse "soon realizes that this system, rather than physical disability, causes many indigestions, headaches, diarrheas, dry mouths, chills; is responsible for much nausea, much exhaustion". Here the writer warns the nurse not to decide whether the disorder is of nervous or physical origin, but to become expert in reporting all sorts of symptoms. The mind is divided up in the conventional way—memory, ideation, etc., with the usual explanations.

In the chapter *Psychology and Health*, the author gives "*adaptability, suggestibility, attention, thought-substitution, habit-formation*, and *will*" as functions of the mind that can influence health. She discusses the self-deceivers, the dreamers, and the important fact

that tendencies to mix the unreal with the real are constantly met in all surgical and medical patients. She urges the nurse to eliminate all unnecessary irritations while helping the patient to face squarely, and adjust himself to, the inevitable. The value of using the hypersuggestibility of almost all sick people to help them is very well put; the art of inspiring confidence, of saying things in the pleasant way, of a drive to substitute new ideas for dismal worrying over symptoms, is described in acceptable terms. "The nurse who can direct attention to other people, to analyzing the sounds of the street, to understanding something of the new life of a hospital or sick room, . . . to current events, . . . a picture, etc., is fixing the patient's attention on something constructive." It is encouraging to see that the nurse must not adopt a "patent, blatant, hollow cheerfulness" and must not let the patient get too dependent.

In opening her discussion of variations from the normal, the author uses a classification that the reviewer cannot follow. Disorders of ideation, reason, and judgment are hard to separate, and it is of doubtful benefit to say that "every departure from the normal mind attitude tends to associate itself with one of the following five states of mental disability: depression, exaltation, perversion, enfeeblement, deficiency."

The definitions that follow are sometimes clear and sometimes excusable because of the audience to whom they are addressed and the principle that every one has a right to his own opinion as to what a term should mean.

The rest of the book gives to the nurse several practical suggestions: how to divert the patient's mind from an immediate want; how to make the goal of health desirable; how to submerge her own preoccupations in her interest in her patient; how to bring interesting, but not too numerous, things to the patient's mind; how to try to get the patient's point of view; and how to carry on in a normal, purposeful way in the face of strongly held delusions. And the book ends by pointing out to the nurse the ways of becoming accurate and of controlling emotional responses. It is rather breath-taking to learn that the nurse of the future will "know the laws of mind as she knows the course of disease" and "will be a sworn, trained ally of the health-accepting mind".

E. D. Bond.

Pennsylvania Hospital.

NOTES AND COMMENTS

Connecticut

A department of public welfare was created by Chapter 307, Laws of 1921. It is the successor of the state board of charities. This department is to organize two bureaus, one to be known as the bureau of adult welfare and the other as the bureau of child welfare. The former is to perform duties heretofore imposed upon the state board of charities. The department is to appoint a secretary, a commissioner of child welfare, one deputy, and supervisors. The commissioner shall have general supervision over the welfare of children who require the care, protection, or discipline of the state. No person may care for more than two dependent, defective, delinquent, or neglected children without first having obtained a license from the department. Licenses are granted by the department upon the recommendation of the commissioner of child welfare. He is to be the chief juvenile-court probation officer of the state and may supervise the probation officer of such courts and assist such courts in their work.

Chapter 336, Laws of 1921, relating to juvenile courts, provides that prior to the hearing of the case of any alleged delinquent child, the court shall, if practicable, cause him to be examined as to his mentality by a competent and experienced mental examiner, who shall make a report of his findings. Whenever a child brought before the court shall be found to be mentally defective, the court may order his commitment to an institution for mental defectives or defective delinquents, or may order him placed on vocational probation. In the latter case, he is given suitable employment and supervised by a probation officer.

By the terms of Chapter 355, Laws of 1921, upon the petition, approved by the state board of education, of the parents or guardians of ten or more educationally exceptional children residing in any school district, the board of school visitors, town school committee, or board of education must establish a school for such children or provide otherwise for their instruction. The term "educationally exceptional children" includes all children over four and under sixteen years of age, who, because of mental or physical handicap, are incapable of receiving proper benefit from ordinary instruction, and who need special educational provisions.

Chapter 265, Laws of 1921, requires a mental as well as a physical examination before the commitment of a child to a county temporary

home. It contains the following provision: "In all cases where the court to which petition is brought for commitment of a child to a county temporary home is situated within fifteen miles of a duly recognized clinic in mental hygiene or institution for the treatment of mental diseases or professional office of a responsible alienist or expert in psychiatry, said court shall, before the hearing is held on the petition, require a mental examination to be made of the child concerned in such petition by such responsible alienist or by an expert connected with such clinic or institution as heretofore described, who shall be appointed by the court for this purpose, provided, in case the town is more than fifteen miles from a duly recognized clinic, the examination shall be made by a reputable physician."

District of Columbia

In the appropriation bill for the District of Columbia for the fiscal year ending June 30, 1923, there is an amendment authorizing the commissioner of the district to acquire a site for an institution for feebleminded persons. This institution must be located in the District of Columbia, Maryland, or Virginia, and is to be constructed at a cost not to exceed $300,000. This amendment was adopted by the United States Senate, but at the time of going to press, the House of Representatives had not acquiesced in it.

Georgia

A bill will be introduced in the 1922 legislature, which convenes in June, to establish a state department of mental hygiene. This department would be charged with the control and administration of the state hospital for mental diseases, the state school for mental defectives, and any other state institutions for the care of these patients that may hereafter be established.

Idaho

A new reception building has been opened at the state hospital, at Blackfoot.

Illinois

A new building for the physically ill has been completed at the Elgin State Hospital. This building accommodates 80 patients and has suitable quarters for ill employees. It has isolation wards for contagious diseases, a dental office, an X-ray laboratory, an eye, ear, nose, and throat room, a minor surgical room, a pharmacy, and a clinical laboratory. A similar hospital building is under construction at the Alton State Hospital and the construction of one at the Dixon State Hospital will soon be started.

Indiana

Plans have been drawn for fourteen new cottages at the Indiana Village for Epileptics, at Newcastle.

Louisiana

Contracts have recently been awarded for the construction of four new buildings at the state hospital for mental diseases located at Pineville. Three of these buildings are to be dormitories, each to accommodate 110 patients. The fourth will contain a dining hall and assembly room.

Maryland

A state reorganization law that has been enacted by the 1922 legislature divides the administration of the state government into nineteen departments. One is the department of welfare. At the head of this department is a board of welfare, consisting of the director of the department, who is to serve as chairman of the board, and four associate members. They are to be appointed without regard to political affiliation, must be not less than thirty years of age, interested and preferably experienced in social welfare, and at least one associate member must be a woman. There is to be a board of mental hygiene in this department, consisting of the commissioner of mental hygiene, who shall serve as chairman of the board, and six associate members. The commissioner must be a qualified physician with at least five years' experience in the treatment of mental diseases. Of the associate members, at least three must be appointed from the city of Baltimore, and at least four shall be graduates of some legally authorized medical college and have practiced their profession for at least five years consecutively just preceding their appointment. The board of mental hygiene is the successor of the state lunacy commission, and assumes all the rights and obligations of this commission.

Minnesota

A research bureau in mental deficiency has been established by the state board of control. The functions of the bureau are as follows: To make all examinations in mental deficiency in connection with commitment of persons to institutions; to conduct a mental clinic at its office in St. Paul, and such other clinics in the state as circumstances may permit; to make other investigations concerning mental deficiency that may aid the board of control in the management of its institutions. This bureau is under the direction of Dr. Fred Kuhlman, formerly head of the research department of the Minnesota School for the Feebleminded.

Missouri

By the terms of a law enacted by the last legislature, special classes in the public schools are provided for children who are not feeble-minded, but are on the border line of mental deficiency, or those who are so backward as to be incapable of receiving proper benefit from instruction in the regular grades. School districts may establish such classes for 20 or more children, and shall receive state aid to the amount of $300 per year for each teacher thus employed. When there are 50 or more children with speech defects in any school district, they may receive special instruction. Such children need not be segregated into special speech classes, but may be taken aside, singly or in groups, during certain periods for speech-corrective training. In 1919, this state enacted a law authorizing special classes for mental defectives in the public schools.

New York

An amendment to the education law has been enacted that establishes a department of extension teacher training in the State Normal School at Geneseo, under which is to be placed the regular school work at the Craig Colony at Sonyea. This law confirms a working arrangement that has been successfully in operation for several years.

A bill that would authorize the appointment of a commission to select a site for a state school for mental defectives in western New York has failed.

An amendment to the insanity law has been approved that directs magistrates in New York City, upon the request of the director of the United States Veterans' Bureau, to commit for observation alleged insane veterans brought before them to the new veterans' hospital in the Bronx. It also authorizes the state hospital commission to transfer veterans of the World War from a state hospital to the veterans' hospital.

Assembly Bill 498, which would provide for trial by jury to determine the question of insanity, failed of passage.

An amendment to the insanity law permitting the medical superintendent of the Matteawan State Hospital to transfer any convict before or after expiration of sentence, who is a mental defective, to the state institution for defective delinquents at Napanoch, has been passed, and also an amendment to the prison law allowing the board of parole for state prisons to parole a male convict to this institution,

and a female convict to the division for defective delinquents at the Bedford Reformatory.

The governor has approved Assembly Bill 139, providing for another civil state hospital to be known as the Brooklyn State Hospital, Creedmoor Division. The sum of $2,979,782.76 has been appropriated, being the unexpended balance of the three million dollars appropriated by Chapter 958, Laws of 1920. This law has grown out of the bills for a military hospital on this site.

The 1922 Appropriation Bill, which has been approved, grants $1,989,600 for new construction and improvements at the state hospitals and a special appropriation of $13,700 for developing occupational therapy. It also allows for five additional social workers.

North Carolina

Contracts have been awarded for the construction of three new buildings at the State Hospital, at Morganton, including a dormitory for men, a house for staff members, and a central kitchen. The total cost of these buildings will be about $100,000.

North Dakota

Chapter 64, Laws of 1921, authorizes parole of the feebleminded from the state institution. It also contains the following provision: "The superintendent may admit to the institution temporarily, without commitment, under such rules and regulations as the board of administration may prescribe, for purposes of observation, such children or adults as are suspected of being feebleminded or idiotic, to ascertain whether or not such person is actually mentally defective and a proper case for care, treatment, and training in an institution for the feebleminded."

Ohio

An administrative code, enacted by the 1921 legislature, divides the administrative functions of the government into the following departments: finance, commerce, highways and public works, agriculture, health, industrial relations, education, and public welfare. Each department has at its head a director who is appointed by the governor with the advice and consent of the senate. There is an assistant director in each department, who must be designated by the director to fill one of the offices created in the department or as the head of one of the divisions created in the department. When a vacancy occurs in the office of the director, the assistant director is to act as

director until the vacancy is filled. The department of public welfare has jurisdiction over the following institutions: state hospitals for mental diseases and Longview Hospital, state institutions for epileptic, feebleminded, deaf, or blind persons, state sanatorium, soldiers' and sailors' home, state industrial schools, penitentiary, reformatories, and prison, and the bureau of juvenile research. The following offices are created in this department: fiscal supervisor, superintendent of charities, and superintendent of pardon and parole. The department of public welfare has all the powers and duties of the board of administration, which is abolished by this act, excepting the power to purchase supplies for the support and maintenance of state institutions. This power is now conferred upon the department of finance. The department of public welfare also has all the powers and duties of the former board of state charities and the board of clemency.

Pennsylvania

Act 208, Laws of 1921, requires that all persons sentenced to serve a term in any jail or penal institution be examined as to physical and also mental condition, within forty-eight hours after admission. This law also authorizes that prisoners who are not mentally normal be segregated from the others.

Act 166, Laws of 1921, provides for the service of process upon the next of kin, in the commitment of an insane person, whenever the court believes this procedure to be in furtherance of justice and for the benefit of the person.

The name of the "Pennsylvania State Lunatic Hospital" has been changed by law to "Harrisburg State Hospital". When this hospital was established in 1845, it was called "The Pennsylvania State Lunatic Hospital and Union Asylum for the Insane."

South Carolina

A bill has been introduced in the 1922 assembly that would require the board of trustees of any school district to provide annually for a medical, mental, and dental inspection of all pupils attending the public schools.

Another bill would give to the state board of public welfare supervision of mentally defective children who are in their own homes, and would authorize this board to visit such children and advise their parents or guardians with reference to their care and training.

A third bill, providing for the instruction of mental defectives in

special classes in the public schools, reads as follows: "Whenever in any school district there are as many as ten mentally defective children of school age, the board of trustees of the said school district shall provide a teacher who shall have no other duties than those of instructing the said mentally defective. Provided that when there are more than ten mentally defective children in any school district, the said district may provide for more than one class. The salary of said teacher or teachers shall be paid by the said school district and the state board of education, each paying one half."

Another bill would require the examination of juvenile delinquents by psychiatrists or psychologists. This bill provides, in the case of any person under the age of eighteen years brought before any magistrate, judge of probate, court of general sessions, municipal court, or any other court having original jurisdiction in the trying of persons charged with violation of any criminal law of this state, that the court shall examine into his mentality. If it appears that the person is not normal mentally, then the court shall remand him back to custody and shall request the state hospital to send a psychiatrist, or the state board of public welfare to send a psychologist, whichever the court may elect, to examine the mind of this person. After the psychiatrist or the psychologist has made an examination, he shall then report to the court the findings.

The above-mentioned bills are in accordance with recommendations made by The National Committee for Mental Hygiene, as a result of a survey of the state that has recently been completed.

Vermont

A law enacted by the 1921 legislature authorizes the supervisors of the insane to detain, for observation for a period of not more than twenty days in any hospital of the state, insane residents of this state who have been apprehended and adjudged insane in another state or country and have been returned to this state. Upon petition brought before any probate court in the state during this period of observation, the supervisors may have such persons committed to the state hospital at Waterbury or the Brattleboro Retreat.

West Virginia

By Chapter 135, Laws of 1921, a state child-welfare commission has been created. The purpose of this body is to study and investigate the laws and conditions in the state relating to dependent, neglected, defective, and delinquent children. The commission is to report the results of its investigation to the next legislature together with its recommendations.

A law enacted by the 1921 legislature, relating to commitment of persons to the industrial home, contains the following provision: "Before committing a girl to the industrial home, the justice, or other authority committing her, shall cause her to be examined by a reputable physician, who is authorized to practice medicine in this state, in order to ascertain whether such girl is sound in mind, and whether or not she is an imbecile or an idiot, or is pregnant, or afflicted with epilepsy, syphilis, gonorrhea, or any other infectious or contagious disease, and as to any other particulars that may be prescribed in the rules and regulations of the state board of control."

Canada

A new building for acute mental cases has just been completed at the Hospital for Mental Diseases, at Selkirk, Manitoba. This building has a capacity of 65 beds.

A training school for mental defectives has been constructed at Portage La Prairie with accommodations for 50 patients. This institution is arranged on the colony plan and 15 additional buildings are contemplated.

A psychopathic hospital has been constructed at Winnipeg that accommodates 40 patients.

A number of new buildings are to be constructed at the Hospital for Mental Diseases, at Brandon. A building for acute mental cases is to be built to accommodate 100 patients. Four units on the colony plan for chronic cases are to be constructed about one mile from the main building. These units will together accommodate 250 patients. One of these units with a capacity for 80 male patients has been completed. A nurses' home has recently been constructed at the hospital.

The National Conference of Social Work

The Forty-ninth Annual Meeting of the National Conference of Social Work will be held in Providence, Rhode Island, June 22-29. The following program has been announced for the Mental Hygiene Division:

Section Meeting I

Extramural Management of Mental Defectives.

1. *The School's Part in Developing an Effective Program.*
2. *Coördinating the Functions of the State and the Community into an Effective System.*

SECTION MEETING II

Teamwork in Mental Hygiene.

1. *A State Program of Mental Hygiene.*

SECTION MEETING III

Mental Hygiene as a Vital Factor in Education.

1. *The Function of the College in Promoting Mental Hygiene.*
2. *Coöperation between the Mental-Hygiene Movement and the Educational Program.*

SECTION MEETING IV

Mental Hygiene of Childhood.

1. *The Clinician's Opportunity.*
2. *The Social Worker's Opportunity.*

SECTION MEETING V

1. *Results and Further Opportunities in the Field of Clinics, Social Service, and Parole.*
2. *The Community's Responsibility in Promoting the Mental-Hygiene Movement.*

The program for the Division on Health includes papers on *Health and Medical Work in Department Stores, The Program of the American Association of Physicians in Industry, The National Health Council and Common Service Committee,* and *Social Hygiene and Venereal Disease Control.*

Among the topics of special interest that will be taken up at the general-session meetings are *The Family as a Factor in Social Evolution, Neglected Fundamentals in Children's Work, The Lawbreaker and Needed Improvements in His Treatment,* and *Underlying Concepts in the World Movement for Health.*

MENTAL HYGIENE AND THE LAW

In an article on the progress of the law during 1921, Professor Chafee, of the Harvard Law School, says regarding certain phases of interest to mental hygienists:

"Reform in the methods of settling questions of mental capacity is urged, not only by lawyers, but by alienists, psychiatrists, and psychologists. Henry W. Taft speaks for the bar in voicing dissatisfaction with medical experts in will cases.[1] Dr. W. A. White, Superintendent of the Government Hospital for the Insane, Washington, D. C., writing on *Expert Testimony in Criminal Procedure Involving the Question of the Mental State of the Defendant,*[2] recommends a statute drawn by the American Institute of Criminal Law

[1] *Comments on Will Contests in New York,* 30 *Yale L. J.* 593, 601 (1921).
[2] *J. Crim. L. & Crim.* 499 (1921).

and Criminology, which authorizes the court to summon experts who may be questioned by both sides; allows the defendant to be examined by these experts and by the state's experts; sends the defendant to a hospital for observation, where all experts shall have access to him; directs each expert to prepare a written report on which he may be cross-questioned, as a substitute for the discredited hypothetical question, which is to be abolished; and also authorizes all the experts, if they see fit, to prepare a joint report. The appointment of experts by the court, which need not be limited to mental experts or to criminal cases, is also recommended by a committee of the Board of Circuit Judges of Wisconsin. Their report, by Judge E. Ray Stevens,[3] reviews the statutes of the states which already allow such experts and submits a draft statute. It is to be hoped that the Michigan decision [4] invalidating such a statute on the ground that the selection of witnesses is not a judicial act represents the isolated attitude of a court which has shown itself noticeably inhospitable to modern legal methods.[5] The value of mental examinations of defendants in criminal cases and of juvenile delinquents has been well proved.[6] It suggests the possibility of similar examinations of witnesses of alleged mental defectiveness or psychopathic tendencies.[7] Although the law has refused to admit lay evidence that a witness' mentality is low,[8] except when it approaches insanity, because such evidence is too uncertain, the report of a Binet-Simon or other intelligence test would be of distinct value to a trained judge in weighing testimony, and attempts to introduce such reports have recently been made.[9] Undoubtedly the wide use of such tests in the army will have its in-

[3] *Expert Testimony*, 10 *J. Crim. L. & Crim.* 188 (1919). See also G. W. Jacoby, *The Unsound Mind and the Law*, 1918; reviewed in 33 *Harv. L. Rev.* 881.

[4] People v. Dickerson, 164 Mich. 148, 129 N. W. 199 (1910).

[5] Anway v. Grand Rapids Ry. Co., 211 Mich. 592, 179 N. W. 350 (1920)—declaratory judgments invalid; Wattles v. Upjohn, 211 Mich. 514, 179 N. W. 335 (1920)—proportional representation invalid; Atty. Gen. *ex rel.* Dingeman v. Lacy, 180 Mich. 329, 146 N. W. 871 (1914)—Detroit court of domestic relations invalid.

[6] See, for example, T. W. Salmon, *Some New Problems for Psychiatric Research in Delinquency*, 10 *J. Crim. L. & Crim.* 375 (1919); H. Olson, *The Psychopathic Laboratory of the Municipal Court of Chicago*, 92 *Cent. L. J.* 102 (1921).

[7] Tom A. Williams, *Some Remarks about Testimony* (summarized from the experience of French psychiatrists and experts in legal medicine), 10 *J. Crim. L. and Crim.* 609 (1920); see also 64 *Sol. L. J.* 579 (1920).

[8] Bell v. Rinner, 16 Ohio St. 45 (1864).

[9] State v. Wade, 113 Atl. 458 (Conn. 1921), after use of Binet-Simon reports of the defendant's mentality, similar reports on witnesses were excluded by the trial court; held within its discretion, as a question of remoteness. These tests were applied to the defendant in State v. Schilling, 112 Atl. 400 (N. J., 1920.)

fluence. The difficulty is, however, that these tests of a witness will go, not to a judge, but to the jury. Hence their value is much less than for the juvenile delinquent, who gets no jury trial. The defendant in a criminal case is also likely to be a better subject of intelligence tests than a witness, if the criminologists succeed in their plan to have the jury pass only on the question whether the accused committed the criminal act with *mens rea*, leaving his mental responsibility and his subsequent treatment, whether in a prison, asylum, or hospital, to be determined by a board on the basis of expert recommendations. The mental capacity of a witness will always have to be left to the jury, so long as there is a jury to determine the issues of fact on which this witness testifies, and it is doubtful whether such a rough-and-ready instrument of justice can cut to the fine lines involved in an intelligence test. W. M. Marston,[10] of the Massachusetts bar, has experimented with blood pressure and other tests to determine the veracity of witnesses, and states that the results of these tests were corroborated by the subsequently disclosed facts, already known to the witness. Lawyers will await the results of such investigations with open minds. They cannot, of course, be substituted in courts generally for present methods of examination until their usefulness is thoroughly demonstrated. If such tests ever are adopted, it is probable that the jury system will have to be abandoned, unless education will have advanced so far that twelve men picked at random will adequately absorb blood pressures, time reactions, and intelligence quotients, and combine the mass into a just verdict. In other words, the jury might also be subjected to an intelligence test."

[10] *Psychological Possibilities in the Deception Tests*, 11 *Crim. L. & Crim.* 551 (1921).

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